CONSENT FORM

**This form is only valid if it is completed filled in**

Last name:                                                                                            V / M / X

Initial(s)/nickname:

Date of birth:

Address:

Phone number(s):

Signature: date: Place:

**By signing this form, the aforementioned patient voluntarily agrees to provide the medical information to:**

Name: Date of birth:

Relationship with patient:

Eventueel 2e persoon:

Name: Date of birth:

Relationship with patient:

**Please tick below what you consent to:**

* Requesting results

* Collection of letters/references
* Consult with a care provider if the GP cannot reach me
* Requesting information from my file
* Calling the practice on my behalf, for example asking when you have an appointment or what policy has been agreed

**We only provide medical data without your permission through to yourself. It is possible to revoke this consent at any time. This form remains valid until you indicate that I no longer wish to grant permission**