MedAustron

Patient Data

EBG MedAustron GmbH
Marie Curie-Straße 5
A-2700 Wiener Neustadt
Österreich

T +43 2622 26 100 - 300

E patient@medaustron.at
www.medaustron.at

Name:_____

Address:_____

ZIP, City:_____

Date of Birth:_____

Social Security Number:_____

Authorization for data transfer and -retrieval

I, _____, herewith authorize and task

Mrs./Mr. _____
(First Name, Surname, Date of birth (TT.MM.YYYY))

to directly and exclusively convey my medical documentation as defined in § 51 paragraph 1 of the Medical Profession Act ("documentation") to EBG MedAustron GmbH ("MedAustron") and herewith revoke any medical or professional confidentiality towards MedAustron regarding the transfer of the documentation to MedAustron.

This documentation includes especially:

- Name;
- Date of birth;
- Information about my condition when taking over counselling or treatment;
- Medical history;
- Diagnosis;
- Course of the disease;
- Kind and scope of the counselling, diagnostic or therapeutic services including prescribing medication;

I hereby give MedAustron my consent to process my personal data mentioned above for the purpose of diagnosis of diagnosis, preparation of a treatment plan and preparation of a treatment contract.

I agree that MedAustron may provide information on all therapy and disease-related information to the authorised representative(s) and hereby release MedAustron from its medical and other professional confidentiality obligations towards the authorised representative(s).

I have been informed that I may revoke this consent in writing at any time.

Place, Date Patient Signature