Deutsches Zentrum für Kinder- & Jugendrheumatologie
Zentrum für Schmerztherapie junger Menschen
Sozialpädiatrisches Zentrum
Lehrkrankenhaus der LMU München

Confidentiality Release Form

Consent for written or oral disclosure of patient data

Patient:
Surname, first name:____________________________ DOB: _____________

address:____

I authorize

- ☐ all persons involved in the treatment
- ☐ the following persons ____

in the employ of the Kinderklinik Garmisch-Partenkirchen gGmbH
(Dt. Zentrum für Kinder- und Jugendrheumatologie, Zentrum für Schmerztherapie junger Menschen, Sozialpädiatrisches Zentrum, Private Schule für Kranke)

to disclose copies of any and all pertinent medical records and informations you have in your possession to

____
Namen + Praxis, Krankenhaus oder Institution + Ort + Telefonnummer

- ☐ At the same time I authorize the person/institution named above to disclose medical data to the person(s) named above in the employ of the Kinderklinik Garmisch-Partenkirchen gGmbH.

I authorise the person(s) in the employ of the Kinderklinik Garmisch-Partenkirchen gGmbH to acquire oral or written information regarding treatment history, course of treatment and aftercare of the patient to ensure optimal patient treatmen.

This is a voluntary declaration which can be revoked at any time, with effect for the future. Revocation will not lead to any disadvantages in treatment.

Name (in block letters):

____

Date: _______________ Signature: ____________________________________
patient / caregiver