Medical Information Release Consent Form

By signing this declaration, I hereby acknowledge that FirstMed-FMC Kft. may hand over medical documentation related to me to the person and/or in the manner I have designated in this declaration. The medical documentation shall be deemed as handed over to me – in case of personal delivery, by the delivery , in case of an e-mail, by the sending and in case of registered mail, by the sending. Therefore, as long as my instructions as stated herrein are followed, I may not raise any claims against FirstMed-FMC Kft. regarding the handing over of my medical documentation, and I may not claim that FirstMed-FMC Kft. has breached my privacy rights with regard to the disclosure of my medical documentation.

Please check all that apply:

☐ I DO NOT CONSENT to having my medical records sent by any means. I will always pick them up personally.

☐ I consent to receiving my medical information at the following e-mail address:_____

☐ I consent to receiving my medical information at the following mailing address by registered mail: _____

☐ I consent to having my medical records sent to the following insurance company: _____

☐ I authorize the following people to receive my records on my behalf personally:

Full Name of Authorized Person:
1. _____ 2. _____

Relationship to You:
1. _____ 2. _____

Mailing Address:
1. _____ 2. _____

Phone number:
1. _____ 2. _____

E-mail:
1. _____ 2. _____

By signing this form I authorize FirstMed-FMC Kft. to use the methods specified above to deliver my medical documentation, including test results, prescriptions or personal medical records.

_____	_____	_____
Patient's Name	Patient's Signature	Date