

Permission form



volg je zorg

Your medical data available through the LSP

YES

I **do** authorize the below-mentioned healthcare provider making my data available through the LSP. I have read all the information contained in the 'Your medical data available through the LSP (National Exchange Point)' brochure / leaflet. **YES:** I have read and understand all the information in the 'Yes! I want to share my medical records; Give permission to share your medical records!' leaflet.

NO

I **do not** authorize the below-mentioned healthcare provider making my data available through the LSP. I have read all the information contained in the 'Your medical data available through the LSP (National Exchange Point)' brochure. **YES:** I have read and understand all the information in the 'Yes! I want to share my medical records; Give permission to share your medical records!' leaflet.

GP or pharmacy details

Which healthcare provider does the form concern?

- my GP
 my pharmacy

Name: _____

Address: _____

Postcode and town: _____

My details Do not forget to sign the form.

Family name: _____

Initials: _____

M F

Address: _____

Postcode and town: _____

Date of birth: _____

Signature: _____

Date: _____

Do you wish to arrange permission for your children?

- For children up to age 12: the parent or guardian gives permission. Please use this form.
- For children aged 12 to 16 who wish to give their permission: both the parent or guardian and the child need to sign this form.
- Children aged 16 and over need to give permission themselves and fill-out their own form.

Details of my children

Complete the below details of the children with respect to whom you wish to give permission. **Do not forget your own signature.**

Family name: _____

Initials: _____

M F

Date of birth: _____

Child's signature: _____

YES NO

Family name: _____

Initials: _____

M F

Date of birth: _____

Child's signature: _____

YES NO

Do you have more than two children? Please complete a new permission form.

Signature parent
or legal guardian: _____

Date: _____

Submit this form to the GP of pharmacy your permission concerns.