**LVR Clinic Patient Declaration on the Release from the Duty of Confidentiality**

I hereby release (first and last name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

the following employees of the LVR Clinic who are subject to secrecy according to § 203 of the German Criminal Code (StGB)

• attending physicians

• attending therapeutic staff

• attending nursing staff

• social services employees

from their duty of confidentiality towards the following persons/institutions:

1. referring physicians \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. doctors who continue to administer treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. psychotherapists who continue to administer treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. social psychiatric service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. other persons/institutions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree that as far as is necessary,

• for my current treatment

• in order to clarify my social benefit entitlements

• on the basis of expert questions

• to ensure my further treatment

• \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

the treatment documents and all findings relating to me may be disclosed.

This declaration of confidentiality can be revoked at any time – even partially.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place, date and signature of the patient

In the event of the patient's inability to issue consent:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place, date and signature of patient’s legal representative