Declaration of consent (private patients)

Declaration of consent to joint billing (in accordance with the official medical fee schedule (GOÄ))

I consent that personal data of mine (i.e. address, date of birth, cost unit, diagnoses and services provided) may be transferred to, as well as processed and stored by *unimed Abrechnungsservice für Kliniken und Chefärzte GmbH* (accounting service for hospitals), Michael-Uwer-Straße 17-19, 66687 Waden, -in the following referred to as *unimed*- for the purpose of joint billing of private and elective medical laboratory services.

I herewith authorize *unimed* to collect outstanding claims in its own name, to commission registered legal service providers with the collection of overdue receivables and to obtain credit verification from credit enquiry agencies.

I acknowledge that the consent is given voluntarily and I am aware that granting or denying consent does not affect my medical treatment in any way. With this declaration I help saving significant additional expenses in the billing of services rendered. These savings help to improve the services offered by Heidelberg University Hospital.

By signing this declaration of consent, I expressly release the employees of Heidelberg University Hospital from their professional obligation to maintain secrecy towards *unimed*. *Unimed* employees are bound by a confidentiality obligation in respect to the processing of data and are subject to this even after termination of their employment. This is governed by §203 StGB. For further information on data protection please refer to: www.unimed.de

I can revoke my consent at any time and without giving reasons. Please consider that the revocation only applies to the future. Processing which has been conducted prior to the revocation is not affected. After revocation, *unimed* is not entitled to process the data any further.

I acknowledge the receipt of information about the data processing and agree to my data being transferred to *unimed* GmbH.

_____   _____
Place, Date   Signature of patient
                                                                           or his/her legal representative

                                                                 _____
                                                                           Name in capital letter