Medical Data Processing Consent Declaration

I, the undersigned, hereby give my explicit and informed consent to the collection, use, and processing of my medical data by **[Healthcare Provider/Institution Name]**, in accordance with applicable data protection laws and the privacy policy of the institution.

Personal Details

Full Name:	_____
Date of Birth:	_____
Patient ID/File Number:	_____
Contact Number:	_____

Declaration

I acknowledge and agree that my medical data (including but not limited to medical history, diagnostic results, and treatment information) may be processed for the purposes of medical diagnosis, treatment, research (when applicable), and healthcare management. I am aware that:

- My data will be processed lawfully, fairly, and transparently.
- Only authorized personnel will have access to my medical data.
- I have the right to withdraw my consent at any time, subject to legal or regulatory exceptions.
- My data may be shared with other healthcare providers as required for treatment or legal obligations.

Signature of Patient / Legal Guardian

Date

Important Notes:

- This consent form is necessary to comply with data protection regulations.
- Read the declaration and privacy policy carefully before signing.
- Retain a copy of this document for your records.
- Contact the institutionâ€™s Data Protection Officer for any concerns or requests regarding your data.