Authorisation for Release of Medical Information

Hereby, I authorise my attending physicians to release medical information and ask them and the relevant in-patient facilities

____ (name of the hospital)
as well as all cooperating health care providers now and hereafter, until revoked, to provide CIP society with a copy of the medical records of below-mentioned patient for the purpose of starting an e-health-record. These documents shall include the entire medical correspondence (surgery reports, anaesthesia monitoring protocols), radiological documents and complete photographic documentation in uncompressed original data format as well as models (file or original in order to be digitised and returned).

Patient:

Surname and first name: ____
For underage patients name of the parent/legal guardian

Date of birth: ____

Place of residence: ____

I am aware that I can revoke this authorisation for release of medical information anytime but not retroactively.

____
Place, date, signature of the patient /legal guardian

Please provide the documents to CIP society either in digital form to info@cipsociety.org or send them by mail to the following addresses: **CIP society, Inzlingerstrasse 200, CH-4125 Riehen, Switzerland** or **CIP society, Burgholzweg 85/1, D-72070 Tübingen, Germany.**