Digital Authorization for the Disclosure of Medical Data

Please complete the following form to authorize NovaSwissMed to share your medical data. The information will be forwarded exclusively to medical institutions required for your treatment, and only within the scope of your medical care.

PERSONAL INFORMATION

First and Last Name:

Date of Birth: Gender:

Address (Street and House Number):

Postal Code: City: Country:

Phone Number: Passport Number:

Email Address:

DECLARATION OF POWER OF ATTORNEY:

I hereby authorize NovaSwissMed, represented by Mr. Mohammad Kheir Naji, to disclose my medical data to other involved medical institutions. The disclosure is strictly limited to institutions required for the clarification, treatment, and coordination of my medical care.

I confirm that all information provided by me is complete, accurate, and truthful. This authorization becomes legally binding upon my signature – whether confirmed digitally or signed by hand.

I consent to the electronic transmission of my medical data.

Place, Date:

Signature (Patient):

Signature of the Authorized Representative of NovaSwissMed: