OZEL YASAM HASTANESI (PRIVATE YASAM HOSPITAL) FORM FOR EXPLICIT CONSENT ABOUT PERSONAL DATA PROCESSING

I have read and understood the **Information Text on Processing of Personal Data**, drawn up by Antalya Yasam Hastaneleri Ozel Saglik Hizmetleri A.S.; and I have been informed about the purpose of processing of my personal data, which is provided in detail under the **Information Text on Processing of Personal Data**, and the institutions, organizations, companies and health-care professionals, to which my personal data is transferred and disclosed, and also the methods for collection of my personal data, and the legal reasons thereto, and my rights for protection of my personal data, and my rights for data security and application; and I acknowledge and agree that My Personal and Private Personal Data shall be transferred to the domestic or international systems, and/or to the group of companies, to which your Hospital is affiliated, and/or to the suppliers, support service providers, archive service providers and business partners, from which you procure services or with which you collaborate, as based on my explicit consent and in compliance with the matters as indicated in the **Information Text on Processing of Personal Data**, except for the circumstances where such data is processed and transferred at the extent as required for the purpose of performance of an agreement and/or if and when so required explicitly by the law or so required for the purpose of fulfillment of its legal obligations by Antalya Yasam Hastaneleri Ozel Saglik Hizmetleri A.S. and also for the purpose of protection of the public health, and performance of the preventive medicine, medical diagnosis, treatment and health-care services, and planning and management of the health-care services and the financing thereof,

I HEREBY AGREE AND ACKNOWLEDGE THE FOREGOING BY GRANTING MY EXPLICIT CONSENT.

I HEREBY DO NOT AGREE AND ACKNOWLEDGE THE FOREGOING.

** 1 copy of the form shall be provided and delivered to you in accordance with the Regulation on Patient Rights. Please notify in case of any failure in provision and delivery of the form to you.*

Please specify in your handwriting that "I have understood what I have read":

.....
Patient's Full Name.....…**Signature**:.....**Date:**...../...../.....**Time:**.....
Patient's E-Mail……

Patient Relative's Full Name:.....**Signature:**.....**Date:** ...../...../.....**Time:**.....
Degree of Affinity: .....
Patient Relative's Full Name:.....**Signature:**.....**Date:** ...../...../.....**Time:**.....
Degree of Affinity: .....

Reason For Obtaining Consent From The Patient Relative:

- The patient has not passed the age of 19 *(Both parents -mother and father - are required to affix their signature. However, in case of the divorce, then the parent, having the custody, is required to affix her/his signature)*
- Mental incapacity / No ability to make a decision *(Her/His guardian or legal representative is required to affix her/his signature)*
- Loss of consciousness.

TRANSLATOR (If the patient has a Language / Communication Problem)

In my opinion, the information that I have been translated by me has been understood by the patient/patient relative.
Translated by: ..... **Signature:** .....**Date:** ...../...../.....**Time:**.....