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<b>Consent to the Use of Patient Data for Medical Research Purposes</b>
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Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**1 I consent to the collection, processing, and scientific use of my patient data as described in the patient information; this includes**

- 1.1 the processing and use of my patient data for medical research at the Medical Faculty of Martin Luther University Halle-Wittenberg in pseudonymized form, as described in Section 3 of the patient information. My pseudonymized patient data will be made available for medical research on a long-term basis. I agree that my data may be used for the entire spectrum of medical research without any project- or topic-specific restrictions. I am aware that I may withdraw my consent in whole or in part at any time (Section 8 of the Patient Information)
- 1.2 the scientific analysis of my pseudonymized patient data by third parties, such as other universities, as part of the medical research described in 1.1. This may also include the transfer of data for research projects abroad, provided that European data protection law applies to such projects or the European Commission has confirmed an adequate level of data protection (see Section 3 of the Patient Information). I will not share in any commercial benefits derived from the research. Furthermore, prior to any transfer to researchers outside my treating institution, the data will undergo further pseudonymization (Patient Information, Section 3).

I consent to the collection, processing, storage, and scientific use of my patient and health data as described in sections 1.1 and 1.2 of the consent form and section 3 of the patient information sheet.

☐ **YES**   ☐ **NO**

I also consent to being surveyed on other medically relevant topics in addition to the use of routine data (Section 2 of the patient information).

☐ **YES**   ☐ **NO**


**2 Option for re-contact**

I consent to being contacted again by research staff at the Faculty of Medicine at Martin Luther University Halle-Wittenberg in order to provide additional information relevant to the research (see Section 6 of the patient information). In this context, I consent to the transfer of my contact information to the Faculty of Medicine at Martin Luther University Halle-Wittenberg in accordance with Section 3 of the patient information.

☐ **YES**   ☐ **NO**

**3 Validity of my Consent**

My consent to the collection of patient data is valid for a period of ten years from the date of my declaration of consent. Data collected from me within these ten years, as described in Section 2 of the patient information, will automatically be available for scientific use. I am free to revoke my consent at any time. Should I return to the geriatric department after ten years have elapsed, I may give my consent

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again. The use of data already collected from me remains permissible beyond this period and is not time-limited, provided there is no revocation (Sections 7 and 8 of the patient information).

#### 4 Right of Withdrawal

My consent is voluntary! I may withdraw my consent in whole or in part at any time without giving a reason by contacting the Medical Faculty of the University of Halle, without incurring any disadvantages. Contact information for withdrawing consent can be found in the patient information (Section 10).

When revoking your consent, you may choose between prospective, anonymized, and prospective/retrospective revocation (see Section 8 of the patient information). Data from analyses already conducted or pseudonymized data that has been shared cannot be removed. In particular, you have the right at any time to request the deletion of your contact information necessary for communication from the Medical Faculty of Martin Luther University Halle-Wittenberg in accordance with Section 8 of the patient information, without necessarily having to withdraw your consent to the provision of your health data.

**I have read the patient information regarding the use of treatment data for research purposes and had the opportunity to ask questions. I understand that my participation is voluntary and that I may withdraw my consent at any time without giving a reason and without suffering any disadvantages as a result. Withdrawal may be made in writing, by fax, or by email (for further information, please contact the designated contact point at the Clinic for Geriatric Medicine at Halle University Hospital; see point 8 in the patient information).**

**I have been informed about the use of my patient data and the associated risks, and I hereby give my consent within the aforementioned framework. I have had sufficient time to consider this, and all my questions have been answered satisfactorily.**

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Date and Place

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Patient Name

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Patient Signature

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I conducted the informed consent discussion. I confirm that I have informed the patient about the nature, significance, implications, and potential risks of the study, and that he or she agrees to participate within the framework described above.

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Doctor Name

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Doctor Signature