

CONSENT FORM FOR THE TRANSMISSION OF FINDINGS

Name patient: _____ **Date of birth:** _____

I hereby agree, that **finding(s) and/or medical report(s)** by the EB-house Austria of

me

my child: _____ **date of birth:** _____

the person I'm trustee for: _____ **date of birth:** _____

may be **transmitted** to the following physician:

Name: _____

Address: _____

may be examined for genetic counselling, if necessary, by the competent medical staff of the EB-house Austria and **discussed** with the following person(s):

Name: _____ date of birth: _____

Name: _____ date of birth: _____

Name: _____ date of birth: _____

Date _____ **Signature of patient, legal guardian, trustee** _____