# Consent – children under the age of 15

**Consent to the exchange of health information in connection with your child's course of treatment**

In connection with your child's examination and treatment at Aleris, it may be necessary to exchange health information with other parties, including the health insurance provider, the child's general practitioner and other parts of the healthcare system. Under the Danish Health Act, this requires consent from one parent or guardian who has parental responsibility for the child. If you share parental responsibility, it is therefore sufficient for one of you to provide consent.

Please indicate your decision for each of the consent statements below. You may withdraw your consent at any time by contacting Aleris. If you have any questions about the content or implications of the consent statements, please feel free to contact us before completing the form.

| **Contact information (child):** | |
|---|---|
| Name: | CPR.-no: |

## Consent to disclose information to the health insurance provider (or region)

If the health insurance provider pays for your child's course of treatment, payment is conditional on Aleris being able to share relevant health information with the insurance provider. If you do not wish to give consent, please contact us by telephone immediately.

O I consent O I do not consent

## Consent to obtain health information from other parts of the healthcare system

May Aleris obtain health information about the child's previous treatments from the child's general practitioner, medical specialists or hospitals? This may include, for example, medical record information from previous treatments that is necessary for the current course of treatment.

O I consent O I do not consent

## Consent to access information on Sundhed.dk

The health record on Sundhed.dk contains the health data that the healthcare system has registered about your child. Only medical specialists at Aleris will be able to access the record.

O I consent O I do not consent

## Protected address

**If you do have protected address, but would like your GP to receive a copy of the medical record, please provice the following information**

Clinic name: _____ Address: _____

**Signature (holder of parental responsibility 1)**

Parent's CPR no.: _____ Telephone no:_____

Date: _____ Signature: _____

**Signature (holder of parental responsibility 2)**

Parent's CPR no.: _____ Telephone no:_____

Date: _____ Signature: _____

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# Health information

| **Contact information (child):** | |
|---|---|
| Name: | CPR.-no: |

## Interpreter

Do you need an interpreter? Yes – contact Aleris as soon as possible

## MRSA

| | |
|---|---|
| Has the child been admitted to a hospital abroad within the past 6 months? | Yes O<br>No O |
| Does anyone in the household work with live pigs on a daily basis? | Yes O<br>No O |

## Allergy

| | |
|---|---|
| Does the child have any allergies? | Yes O<br>No O |

If yes, what kind? _____

## Height and weight

The child's height: _____ cm

The child's weight: _____kg

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