Consent to disclose my information to health insurance

Name:	Cpr-no.:
Telephone:	E-mail:

If your health insurance covers your examination or treatment, it is a condition for coverage, that you consent to the insurance provider receiving a copy of your medical record. If you do not wish to give consent, contact the staff promptly.

I consent ○

I do not wish to exchange information ○

Signature

Date: _____ Signature: _____

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