PATIENT CONSENT FORM

Patient Consent for Use/Disclosure of Personal Information

Patient Name: _____ Date of Birth: _____

Country: _____

I understand that the patient's information is private and confidential. I understand that staff at the FMF & AID Global Association work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal information.

I understand that the FMF & AID Global Association may use and disclose the patient's personal information to help provide health care to the patient at the patient's request, and to take care of other health care operations. In general, there will be no other uses and disclosure of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone or himself/herself.

The FMF & AID Global Association has a detailed document on its homepage called "GDPR" policy (General Data Protection Regulation" (https://www.fmfandaid.org/gdpr). It contains more information about the policies and practices protecting the patient's privacy. I understand that it is my responsibility to read this policy before signing this agreement.

The FMF & AID Global Association may update its "GDPR" policy if considered necessary. However, the most current version of this document will always be found and can be downloaded any time from the FMF & AID website (see above link).

Under the terms of this consent, I can ask the FMF & AID Global Association to limit how the patient's personal information is used or disclosed to carry out treatment or health care operations. I understand that the FMF & AID Global Association does not have to agree to my request.

I may cancel this consent in writing at any time by doing one of the following:

1. Sign and date the form that the FMF & AID Global Association can provide me. This form is called the "Revocation of Consent for Use and Disclosure of Personal Information"; OR
2. Write, sign and date a letter to the FMF & AID Global Association. If I write a letter, it must state that I want to revoke my consent, authorizing the use of disclosure of the patient's personal information for treatment and health care operations.

If I revoke this consent, the staff at the FMF & AID Global Association do not have to provide any further health care support/services to me. My signature below indicates that I have been given the chance to review a current copy of the FMF & AID Global Association's "GDPR" policy. My signature means that I agree to allow the FMF & AID Global Association to use and disclose my personal information to refer me to specialists, discuss my treatment options, and health care operations.

_____ _____

Name in block letters & Patient/Legally Authorized Individual Signature Date

_____

Relationship to Patient (If signed by anyone other than the patient)