

### **Release from Obligation to Secrecy**

.....  
(name of patient /legal guardian / date of birth)

.....  
(address of the patient)

.....  
(mobile phone)

.....  
(e-mail address)

**I hereby release from obligation to secrecy any involved party to conduct all necessary actions  
on my behalf related to my diseases and treatment at University Hospital Duesseldorf.**

.....  
(Date /signature of the patient)

### **Authorization**

I .....  
(name of patient /legal guardian / date of birth)

**Hereby authorize**

.....  
(name of authorised person / date of birth)

**to conduct all necessary actions on my behalf regarding my treatment at University Hospital  
Duesseldorf, Germany.**

.....  
(Date /signature of the patient)