

PATIENT'S EXPLICIT CONSENT FORM WITHIN THE LAW ON THE PROTECTION OF PERSONAL DATA (KVKK)(GENERAL)

I have been directed to read the patient clarification text on the Processing of Personal Data Protection.

Besides, I have been informed that I can also find the text on the web site indicated below;(<https://drniatkaya.com/>).

I have understood that my consent is not needed for my medical data to be processed during the treatment process, which is already regulatory. I am giving my explicit Consent on the following issues. Within this context (*please circle your choices or put a check mark on your preferences.)

1. My personal data and private personal data are circulated abroad during the use of services provided from abroad (I understand that e-mail communication, instagram, facebook, whatsapp, patient registration site and appointment program are provided from abroad),

☐ I agree. ☐ I DON'T agree.

2. My before- after photos of the operation will/can be shared with academical purposes in the occupational conferences,

☐ I agree. ☐ I DON'T agree.

☐ I let my photos be shared as long as my identity is classified, by blurring/ darkening the related facial areas (such as eyes, etc.) to hide my identity.

3. My pre-post operation photos will/can be shared on social media (facebook, instagram, website, etc.)

☐ I agree. ☐ I DON'T agree.

☐ I let my photos be shared as long as my identity is classified, by blurring/ darkening the related facial areas (such as eyes, etc.) to hide my identity.

4. My pre- post operative photos will / can be shared to set an example for the new patients in the clinic,

☐ I agree. ☐ I DON'T agree.

☐ I let my photos be shared as long as my identity is classified, by blurring/ darkening the related facial areas (such as eyes, etc.) to hide my identity.

5. To receive birthday messages, holiday celebrations etc. Or to receive new announcements or reminders about a new service or a product via phone- calls, texts, emails.



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accept and declare that I give my informed consent to the processing of personal / private personal data
in the above-mentioned issues with my free will.

atient's Name- Surname:

☐

I agree.

☐

I DON'T agree

Date- Signature:

PATIENT'S RELATIVE Name Surname :..... Signature
:.....

Date:/...../..... Time:..... Degree of Affinity:

(If the patient is under the age of 19, signature is taken from both parents - mother and father, and if the family is divorced, it is signed by the guardian. If there is a guardian or legal representative, signature is taken from that person.)

TRANSLATOR *(If the patient is a foreigner)* In my point of view, the information I have translated,
was understood by the patient/ Patient's relative.

Name- Surname of the Translator: Signature :Date:
...../...../..... Time:.....