



Personal Data Clarification and Consent Form

As **Dmax Health Healthcare Services**, it may be necessary for us to obtain, record, and store your personal and health data to carry out the services I will provide to you, within the limits required by the service to be provided.

The health data that we must record to provide healthcare services to you are legally considered “sensitive personal data.” According to Article 6, Paragraph 2 of the Law No. 6698 on the Protection of Personal Data, “Processing sensitive personal data without the explicit consent of the data subject is prohibited.” As your health data can only be recorded with your explicit written consent, except for specific conditions stipulated by law, it is mandatory to obtain this consent from you.

Information Notice

1. This consent covers the personal data you provide to us verbally, in writing, visually, or electronically during your examination, as well as personal data transmitted to us via internet and mobile applications or electronically, or obtained in our clinic (such as test results, prescriptions, camera recordings, videos, photos, etc.).
2. This includes, but is not limited to, personal health data necessary for the services we will provide to you and obtained for this purpose, such as your name, surname, ID number (or passport number or temporary ID number if you are not a Turkish citizen), place and date of birth, marital status, gender, and other identification information, various identification documents, address, phone number, email address, financial information such as your bank account number and IBAN number, medical history in your clinical file, information about your past illnesses, examination data, data related to the procedures applied to you, prescription information, photos, any images, audio/video recordings, laboratory and imaging results, test results, health data related to sexual life, data concerning private health insurance, and Social Security Institution data.
3. Your personal data, including the data shared by you and obtained during the provision of the service, will be processed for the purpose of determining, providing, and evaluating the health service that may be offered to you.
4. Your personal data will be recorded only to the extent necessary for the healthcare service to be provided to you and will be stored in our system/archive "for no longer than necessary to achieve the purposes of their collection" in accordance with the Law No. 6698 on the Protection of Personal Data and relevant legislation. The data processed within this scope will be protected as professional secrets, kept confidential, and will not be shared with third parties/institutions/organizations.
5. However, we remind you that your personal data may be reported to competent authorities in cases where the confidentiality of personal medical records needs to be limited, such as the obligation to report contagious diseases to the competent authorities as regulated in Article 58 of the Public Health Law No. 1593, or in cases of legal obligations like the obligation to report crimes, and may be shared with another physician for consultation purposes regarding your health status.
6. Requests from public institutions, judicial authorities, and other official bodies for the transmission of your data will be evaluated based on the purpose of the request, whether the requested data aligns with the purpose, whether the requested purpose can be achieved without transmitting your data, and whether the data transmission is necessary in a democratic society. Requests that do not meet all these criteria will not be fulfilled.

7-) Regarding the data recorded by us, and in accordance with the Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data (Council of Europe Convention No. 108), Article 8 of the European Convention on Human Rights, Article 20 of the Constitution, and the Law No. 6698 on the Protection of Personal Data:

To learn whether your personal data is being processed and the scope of any processed data,

- If your personal data has been processed, to obtain information regarding this processing, access these data, and request copies,
- To learn the purpose of the processing of your personal data and whether they are being used in accordance with that purpose, and to find out whether they have been transferred to a third party or institution within the country or abroad, as well as to request notification of any changes in your personal data to those who have received such data,
- To request the correction of your personal data if they have been processed incompletely or inaccurately (You have been informed that this right can be exercised by personally or in writing applying to our clinic at the address),
- To request the concealment, deletion, or destruction of some of your data.

II. CONSENT STATEMENT

I hereby declare that I have read and understood the Personal Data Clarification and Consent Form prepared by Dmax Health Healthcare Services and that I have also been verbally informed about the matter. I have been informed about the purposes of processing my personal data, the methods of collection, and the legal grounds, my rights regarding the protection of my personal data, the obligatory cases where my data may be transferred, data security, and my application rights as detailed in the Personal Data Clarification and Consent Form.

I give my explicit consent for all my personal data, including my health data, to be recorded, stored, and shared in the obligatory cases mentioned, by the employees of **Dmax Health Healthcare Services** and the institutions they collaborate with, in accordance with the above-mentioned principles. Additionally, I accept that **Dmax Health Healthcare Services** may contact me through the mobile devices, internet, or postal services I have specified below. As required by the Patient Rights Regulation, one copy of this form will be provided to you. If the form is not provided to you, please inform the person obtaining consent.

PATIENT'S NAME AND SURNAME.....

ADDRESS:.....
.....

E-MAIL:

PHONE:.....

SIGNATURE: **DATE**/...../..... **TIME:**.....

In case the patient is under 18 years old or is unconscious

Name and Surname of the Patient's Relative:.....

SIGNATURE:..... DATE:/...../..... TIME

Relationship to the Patient:

Please write in your own handwriting: "I have read, understood, approve, and accept."

.....

IF APPLICABLE, INTERPRETER (If the patient has a language/communication problem)

According to my opinion, the information I translated has been understood by the patient/patient's relative.

Name and Surname of the Translator:.....

SIGNATURE: DATE:/...../..... TIME: