CONSENT FORM FOR SHARING PROFESSIONAL INFORMATION

I, the undersigned below, as a licensed healthcare professional, hereby give my consent to:

_____

[CLINIC/COMPANY NAME]

located at

_____

[CLINIC/COMPANY ADDRESS]

to publish my professional details on their subpage of the website www.mydoctormalta.com, for the purpose of informing the public about the services offered in collaboration with the clinic. Details to be published include the following:

1. My full name: _____
2. My professional title and qualifications: _____
3. My specialization or areas of expertise: _____
4. Services provided at the clinic: _____
5. Professional affiliations with the clinic: _____
6. Contact details for booking purposes, as applicable:
    - Address of the clinic: _____
    - Phone number: _____
    - Email address: _____
    - Any additional relevant contact information: _____

_____

I understand that this information will also be associated with my professional profile on the website www.mydoctormalta.com.

Right to Withdraw Consent

I acknowledge that I can withdraw my consent at any time by sending an email to info@mydoctormalta.com.

Declaration

By signing this form, I confirm that I have provided accurate and up-to-date information and that I fully understand and agree to the terms outlined above.

Signature: _____

Full Name: _____

Professional Title: _____

Specialization: _____

Date: _____

Personal Stamp: _____