CONSENT FORM FOR SHARING PROFESSIONAL INFORMATION

This consent form is issued in accordance with applicable Maltese legislation, including the General Data Protection Regulation (EU) 2016/679 (GDPR) and the Data Protection Act (Cap. 586 of the Laws of Malta).

I, the undersigned healthcare professional, hereby voluntarily give my explicit consent to the pharmacy identified below to publish my professional details on its designated subpage(s) of the website **www.mydoctormalta.com**, for the purpose of informing the public about healthcare services offered in collaboration with the said pharmacy.

Pharmacy Name:	
Pharmacy Address:	
Telephone Number:	
Email Address:	

Professional Details to be Published

Full Name:	
Professional Title & Qualifications:	
Specialisation (if applicable):	
Services Provided at the Pharmacy:	
Additional Relevant Information:	

Right to Withdraw Consent

I acknowledge that I may withdraw this consent at any time by submitting a written request via email to **info@mydoctormalta.com**. Upon withdrawal, my professional information shall be removed within a reasonable timeframe.

Declaration

By signing this form, I confirm that the information provided is accurate, complete, and up to date, and that I have read, understood, and agree to the terms of this consent.

Signature:	Date:
Full Name:	Title (Ms/Mr/Dr):
Personal Stamp:	