CONSENT FORM FOR SHARING PROFESSIONAL INFORMATION

I, the undersigned below, as the owner of / person in charge of

_____

[CLINIC/PHARMACY/COMPANY NAME]

located at

_____

[COMPANY ADDRESS]

hereby confirm that

_____

[NAME OF THE PROFESSIONAL]

provides their services at my company at the address:

_____

_____

I give my consent for the following information to be published on the website www.mydoctormalta.com:

1. The professional's name and their affiliation with my company.
2. The address of my company where the professional provides services.
3. For booking purposes of the professional's services, the following details may be used:
   address: _____

   phone number: _____

   email: _____

   and any additional relevant contact information:

_____

_____

Additionally, I give consent to add this information to

_____

[PROFESSIONAL'S NAME]

profile on the website www.mydoctormalta.com.
I acknowledge that I can withdraw this consent at any time by sending an email to info@mydoctormalta.com.

Signature: _____

Name: _____

Position: _____

Date: _____

Company stamp: _____