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, acting as the owner or person in charge of the entity identified below, hereby confirm that the healthcare professional identified in this form provides medical or healthcare services at my clinic, pharmacy, or company.

Clinic / Pharmacy / Company Name:	
Address:	

Name of the Professional (the healthcare professional providing services at the clinic, pharmacy, or company to whom this consent relates):	

Consent for Publication of Information

I hereby give my explicit consent for the name of the clinic, pharmacy, or company identified above to be published on the website www.mydoctormalta.com as the place at which the healthcare professional provides medical or healthcare services, together with the following information:

1. The name of the healthcare professional and their professional affiliation with the clinic, pharmacy, or company named above.
2. The address of the clinic, pharmacy, or company, as stated above.
3. For the purpose of booking the healthcare professional's services, the following contact details of the clinic, pharmacy, or company may be published:

Telephone Number:	
Email Address:	
Additional Relevant Contact Information:	

Additionally, I give my consent for this information to be included on the professional profile of the above-mentioned healthcare professional on the website www.mydoctormalta.com.

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

Signature:	Date:
Name:	Position:
Company Stamp:	