**Healthcare Professional Consent Form**

I, **[Insert name]**, hereby consent that Coloplast may freely use the information and photos in the case report regarding patient no. **[Insert patient no. (not name)]** including on Coloplast hosted websites.

If relevant I accept to publish the case report (e.g. as poster or in journals).

I confirm to have the necessary approvals from the healthcare facility and/or local authorities to perform and publish the case report.

I confirm to have received a signed consent form from the patient, accepting the use of anonymous information and photos collected. The patient was able to withdraw the consent form at any time during the treatment period without any consequences for future treatment.

Any information and photos from the case report forms may be shared with and used in connection with Coloplast's business and subsidiaries worldwide without limitation for product development, scientific and/or general marketing purposes via the Internet, TV, radio, congresses, in the form of e.g. printed material, videos, posters, as well and other similar medias.

Coloplast sales people may contact you on the basis of the case report form with the purpose of discussing Coloplast products.

No separate reward or payment will be offered for these Records made as a result of this Agreement.

Data will be collected and processed across Coloplast’s network which may include processing of personal data outside of the European Economic Area. Coloplast fully endorses and adheres to the principles of data protection as set out in the European Data Protection legislation. For more information about data privacy please refer to [www.coloplast.com/global/privacy-notice](http://www.coloplast.com/global/privacy-notice). I agree to visit the site for further information.

I understand that I may at any time withdraw my consent to any future use of the Records.

Coloplast reserves the right to inform your employer of the existence of this declaration.

**Please use Latin alphabet**

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
| Country: |  |

Date: \_\_\_\_/\_\_\_\_ 20 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_