**EXPLICIT CONSENT FORM REGARDING THE PROCESS OF PERSONAL DATA**

 BMK Gözeten Hizmetleri A.Ş. We request your explicit consent for ("Laura Dental Center ") to process and transfer your personal data given in detail at the Clarification/Information Form for Processing Personal Data as necessitated by reasons stated below, other than the accomplishment of contract, as foreseen clearly in law, as required to carry out legal responsibilities and to protect public health, to conduct protective physician, medical diagnosis, treatment and care services, to plan and manage the finances of medical services:

**Gathering, Processing Personal Data and Process Reasons**

 I was informed by reading the Clarification/Information Form for Processing Personal Data that you gathered my personal data via Call Center, internet, mobile applications, physical environments and similar channels, in verbal, written, visual or electronic form to be able to provide me a high quality service, based on the features of the provided service.

 In this extent, all my primary general and private personal data, especially my personal health data that are necessary to conduct all medical diagnosis, examination, treatment and care services are listed below;

□ ID information such as my name, surname, TR ID no, if I am not a Turkish citizen, my passport number or temporary TR ID no, date and place of birth, marital status, and gender, and my TR ID or Driver Licence copy that I submitted,

□ Communication information such as my address, phone number, e-mail,

□ Financial data such as bank account no, IBAN no,

 □ Health and sexual life data gathered during conducting medical diagnosis, treatment and care services such as my laboratory and image results, test results, examination data, prescription data that I submitted for the follow up of my file,

 □ My response and comments that I shared to evaluate your services,

 □ My close circuit camera system image and voice recordings gathered during my visit to your clinics,

 □ My recorded phone calls gathered when I contacted your Call Center,

 □ My data of personal health insurance and Social Security Service data to finance and plan health services,

 □ My vehicle license plate data ,

□ Visiting information, IP address, scanning information gathered when I visit your website and use your mobile applications, and medical documents, surveys, form information and location data that I submitted of my own volition,

 I was informed that my personal data stated above and my special personal data may be processed with the reasons below:

□ To protect public health, to conduct protective physician, medical diagnosis, treatment and care services,

□ According to the related legislation, to share the information demanded by Ministry of Health and other public institutions and organizations,

□ To satisfy legal and regulative requirements,

 □ In regards to the financing, and meeting the expenses of tests, diagnosis and treatment, and to check condignation, to share the information demanded by private insurance companies, via your Patient Services, Financial Affairs, Marketing departments,

 □ To inform me about my appointment via your Call Center and Digital Channels,

□ To confirm my identity via Patient Services, Health Professionals and Call Center,

 □ To plan and manage the internal administration of the institution via our Clinic Management,

□ To conduct analyses in order to improve the health services via Quality, Patient Experience, Information Systems,

□ To provide training to your employees by Human Resources and Quality departments,

□ To observe and obstruct unauthorized and abusing processes via Auditing and Information Systems departments,

 □ To conduct risk management and quality development activities via Quality, Patient Experience, Information Systems departments,

 □ To perform billing for the provided services via Patient Services, Financial Affairs, Marketing departments,

 □ To confirm your relation with institutions contracted with your Clinic via Patient Services, Financial Affairs, Marketing departments,

 □ To respond to all my questions and complaints related to your health services via Clinic Management, Patient Experience, Patient Rights, Call Center departments,

 □ To take all the necessary technical and administrative precautions for data security of your clinic's system and applications, via Clinic Management, Information Systems departments,

□ To provide campaign participation and campaign information, and to design and transmit special content, concrete and abstract profits in Web and mobile channels via Marketing, Media and Communication, Call Center departments,

 □ To measure, increase and investigate patient satisfaction via Clinic Management, Patient Rights, Patient Experience departments,

□ To conduct training and education activities via education institutions that cooperate with the institution. I was informed in detail that "My Personal and Special Data" stated above, will be recorded and protected in physical and electronic archives by Laura Dental Center and external service providers, in accordance with regulations and with great care. Transferring Personal Data My personal information could be shared with the following, in accordance with No 3359 Health Services Basic Law, no 663 Statutory Decree Regarding the Organization and Duties of Ministry of Health and Its Affiliates, no 6698 Protection of Personal Data Law, Processing of Personal Medical Data and Protection of Privacy Legislation and Ministry of Health regulations and miscellaneous regulations, and with the reasons explained above;

 □ Ministry of Health, sub-divisions of the ministry and family practice centers,

 □ Private insurance companies

 □ Social Services Institution,

 □ Security General Directorate and other law enforcement forces,

 □ General Directorate of Census,

□ Judicial authorities,

□ If I was to be transferred, with another medical institution that I was transferred to or that I've applied to,

□ My legal, authorized representatives,

□ Third persons that provide consultancy to you including your lawyers, tax advisers and auditors,

 □ Regulator and auditor institutions and official authorities,

□ Your suppliers, support service providers, archive service providers and partners that you are using their services as a company or in coordination with (for a more detailed information, I know that I may apply to your hospital in writing).

By filling the "Application Form Regarding Protection of Personal Data Law" in "<https://www.lauradentalcenter.com/>website, I know that I can;

* Personally deliver your legal requests to Güzeloba Mah. Çağlayangil Cad.No:19 B Muratpaşa/ANTALYA address,
* Send them via a Notary,
* Via the call center +90(538) 098 08 53
* An e-mail address recorded in our system, as secured email or with mobile signature to the info@lauradentalcenter.com address.

I EXPLICITLY CONSENT THAT I have read and understood the Clarification/Information Form for Processing Personal Data prepared by Laura Dental Center, that I was informed about the reasons for processing my personal data given in detail at Clarification/Information Form for Processing Personal Data, the institutions, organizations, companies and medical professionals whom it was transferred to, their gathering methods and legal reasons, my rights in regards to protecting personal data, and my rights for data protections and application,

 The protection, processing and transfer of my personal data given in detail at the Clarification/Information Form for Processing Personal Data as necessitated by reasons stated below, other than the accomplishment of contract, as foreseen clearly in law, as required to carry out legal responsibilities and to protect public health, to conduct protective physician, medical diagnosis, treatment and care services, to plan and manage the finances of medical services.

\*In accordance with the Patient Right Regulation, one copy of this form will be given to you. State it if the form is not given to you.

 **CONSENT**

Please write, “I understood what I read” with your own handwriting:…………………………………………

Patient Name and Surname……………………………… Signature:…………Date: ……./……./………Hour:…....

Patient Relative Name and Surname:………………….. Signature:…………Date: ……./……./………Hour:…....

Degree of Relation: ……………………….

Patient Relative Name and Surname:……………….. Signature:…………Date: ……./……./………Hour:…..

Degree of Relation: ……………………….

 **The Reason for Taking the Consent from the Patient Relative:**

 □ The patient has not passed the age of 18 (signature is taken from both parents –mother and father. However, in case of divorced parents, the signature is taken from the parent who has the custody of the child)

□ Patient has mental incapacity /decision making incapacity (Signature is taken from the legal guardian or legal representative)

 □ Patient is unconscious. ----------------------------------------------------------------------------------------------------------------------------------------------------------

**INTERPRETER** (If the patient has a language / communication problem) In my opinion, the information I translated is understood by the patient/patient's relative.

Interpreter Name and Surname:……………………….. Signature:………….Date: …../……./……… Hour:.…