



Herzliya
Medical
Center

Waiver of Medical Confidentiality

I, the undersigned, hereby confirm that the results of any therapeutic and/or diagnostic activities may be sent by email or regular mail, fax or using other means of communication.

I, the undersigned, hereby confirm that the results of any therapeutic and/or diagnostic activities may be discussed in the regular course of business conducted by any institutions, departments or suppliers of health services - laboratories, clinics, hospitals, medical personnel, etc. - that participate in the diagnostic and/or therapeutic process.

I, the undersigned, hereby exempt Herzliya Medical Center and any organizations, departments, clinics, laboratories that participate in the diagnostic and/or therapeutic process from any responsibility to maintain medical confidentiality that they bear or may bear according to the laws of the State of Israel.

I, the undersigned, hereby confirm that neither I, nor my representatives have or will have any demands and/or claims with respect to breach of medical confidentiality.

I, the undersigned, prefer the results of diagnostic and/or therapeutic activities to be received via email.

I, the undersigned, request that the results of diagnostic and/or therapeutic activities be sent to my agent (representative) via email.

For Agent Company (Representative) Use		For Privat Use	
Company Name		Patients Name*	
Agent's (Representative) Name		ID/Passport Number*	
E-mail		E-mail*	
Fax			

Date*:

Signature*: _____