FO12 – Request for therapeutic relationship(s)

1. Person concerned (patient)

First name(s)* : Last name* :

National Register Number* : Date of birth* :

Email : Sex* : ☐ M ☐ F

Address :

2. Legal representative of the patient (if applicable)

First name(s)* : Last name* :

National Register Number* : Date of birth* :

Email :

Address :

3. Healthcare professionals

Healthcare professional 1

First name(s) : Last name :

INAMI number : or stamp :

Type of relationship :

☐ General practicioner ☐ Outpatient physician (outside hospital) ☐ Hospital physician ☐ Other (please specify)

Healthcare professional 2

First name(s) : Last name :

INAMI number : or stamp :

Type of relationship :

☐ General practicioner ☐ Outpatient physician (outside hospital) ☐ Hospital physician ☐ Other (please specify)

Healthcare professional 3

First name(s) : Last name :

INAMI number : or stamp :

Type of relationship :

☐ General practicioner ☐ Outpatient physician (outside hospital) ☐ Hospital physician ☐ Other (please specify)

Healthcare professional 4

First name(s) : Last name :

INAMI number : or stamp :

Type of relationship :

☐ General practicioner ☐ Outpatient physician (outside hospital) ☐ Hospital physician ☐ Other (please specify)

Healthcare professional 5

First name(s) : Last name :

INAMI number : or stamp :

Type of relationship :

☐ General practicioner ☐ Outpatient physician (outside hospital) ☐ Hospital physician ☐ Other (please specify)

Healthcare professional 6

First name(s) : Last name :

INAMI number : or stamp :

Type of relationship :

☐ General practicioner ☐ Outpatient physician (outside hospital) ☐ Hospital physician ☐ Other (please specify)

Please note: Without indication of the type of relationship, your request cannot be processed.

By signing this document, I formally request Abrumet to:

- Register the access relationship(s) with the healthcare professional(s) designated above.
- Grant them access to the patient's medical documents shared on the Brussels Health Network, provided that they are themselves registered on it.
- Freely proceed with the patient's registration on the Brussels Health Network if they are not yet registered.

Document to be sent dated and signed to: **info@abrumet.be** or Rue de la Montagne 11, 1000 Brussels. Please attach a copy of both sides of the patient's identity card

Done on

Signature of the patient or legal representative (if applicable)*

The patient's GDPR rights (access, rectification, etc.) may be exercised with the data controller or via Abrumet's DPO (dpo@abrumet.be), who will forward your request to them. The Privacy Regulations is accessible via this link.