Medical Tourism Guest Privacy Consent Form

Guest Information

Full Name

Date of Birth

Passport/ID Number

Contact Number

Email Address

Consent Statement

I understand and consent to the collection, use, and disclosure of my personal and medical information for the purposes of providing medical tourism services and treatments. I acknowledge that my information may be shared with healthcare providers and organizations involved in my care.

I am aware of my rights to privacy and my ability to withdraw consent at any time by notifying the service provider in writing.

☐ I have read and understood this privacy consent form.

Signature

Signature

Date