CONSENT FORM

"Study on the course of the disease in persons who tested positive for SARS-CoV-2 or who were affected by COVID-19" (CoVerlauf)

- I have received and read the written study information.
- I was given the opportunity to ask questions and all of my questions were sufficiently answered.
- I was given sufficient time to make my decision.
- I voluntarily consent to participate in this study. I was informed that I can rescind my consent at any given time without being required to give reasons for my decision or having to fear negative consequences.

In addition to consenting to the use of my data collected via questionnaire, I also consent

-Please mark all applicable options-

☐ that my health insurance data are requested from my health insurance company, and, after pseudonymization, linked to the study data.

☐ that my general practitioner / physician may be contacted to verify medical information if questions arise from the questionnaire data.

☐ that data collected by the Bremen Health Office concerning my person can be used in the context of this study.

☐ Please inform me about the results of this study.

Data protection

I consent to the recording and storage of all data collected about me during this study and, after pseudonymization, their usage in scientific analyses and publications.

-Please use printed letters-

Participant:

Last name: | First name:

Date: | Signature:

(Participant or, for minors, a legal representative)

Please fill out both sides of this sheet ➡

Contact form

To enroll in this study, please fill in the following information:

-Please use printed letters-

Last name: | First name:

Street: | No.:

Postal code: | City:

Date of birth: | Date you were tested for SARS-CoV-2:

Email address:

Phone number:

Minors below 18 years

Name of a legal representative:

Would you like to receive the questionnaire via email or complete a telephone interview?

☐ Via email

☐ Via phone, preferably in the morning / afternoon / evening ***(please indicate preferred option)***

In addition, please provide the following information:

-Please use printed letters-

Name of the health insurance company:

Health insurance number:

Name your general practitioner / physician:

Address of his / her medical practice:

Please fill out both sides of this sheet ➡