COASTAL ORTHOPAEDIC GROUP

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Patient Consent to Disclosure of Information (POPI Act)

NOTE: The Privacy Statement must be made available to the patient before he/she signs this document.

I, _____ (full names and surname), am an adult person (18 years or older) / the parent or legal guardian of a child younger than 12 years of age / a child 12 years or older (delete what is not applicable), I hereby give my consent, freely and voluntarily and with knowledge of the implications of such consent, and by so doing authorise the Practice to disclose the specific information outlined herein to the entities / person(s) mentioned and to the extent identified herein:

A reference to the patient, includes any person who may consent or contract on behalf of a patient, and includes the person responsible for payment of the patient's accounts.

(a) The privacy and security of the personal information of patients (who include any person who may consent or contract on behalf of a patient) are important to us. We will only process personal information, which includes collect, use, store and share such information, in accordance with the Privacy Statement of the practice and if the processing is permitted by law, for a legitimate interest or if the patient has provided consent.

(b) The practice must include codes on accounts that disclose the patient's diagnosis, known as ICD-10 codes. These codes are necessary for funding decisions and benefit allocations by funders such as the patient's medical scheme, the Compensation Commissioner for Occupational Injuries and Diseases and the Road Accident Fund.

(c) **Consent:**

(i) I confirm that a copy of the practice's Privacy Statement has been made available to me. I confirm that I had an adequate opportunity to read this Statement and that I fully understand my rights in respect of my information held by the practice and how the practice will process my personal information. I declare that all my questions have been answered satisfactorily. I understand how the practice will process my personal information and with whom it will be shared. ☐

(ii) I confirm that I provide consent of my own free will without any undue influence from any person whatsoever. I have received all the information required to provide consent. ☐

(iii) I consent to the following specific processing activities of my personal information by the practice:

1. I consent that my provided contact number and email may be used for administration purposes within the Practice (e.g. sms reminders of appointments etc.) ☐

2. The submission of information relevant to my diagnosis and treatment to my medical scheme / other funder, if required; ☐

3. Another person or entity an get a copy of specific health record (e.g. copy of sick certificate, medical report, copy of medical file, prescription etc.) ☐

4. The inclusion of relevant health information in referral letters and when providing reports about your treatment to referring practitioners; ☐

5. To sharing of relevant information with bodies performing peer review of practitioners or clinical practice audits, subject to confidentiality undertakings. ☐

6. Another person is authorised to sit in at the consultation / procedure at the request of the Patient. Such a person (e.g. parent, a spouse, partner etc.) would then hear and/or see information that would otherwise remain confidential between the patient and healthcare ☐

7. That another person (such as family members) receive updates on how patient is doing before, during and /or after a procedure ☐

8. Another person (e.g .parent, a spouse, partner, family members etc) is authorised to consent to treatment and care when the Patient cannot (e.g. when the patient is unconscious), and can receive information about the Patient which will enable them to make the decision. ☐

9. I consent to that the practice may submit my accounts to my medical scheme / other funder and any person responsible for payment of the accounts on my behalf. ☐

10. A medico-legal report, a report constituting a second opinion, a report to an attorney, Insurance Company etc. ☐

11. The employer of the Patient is authorised to request specific information, including the nature of the patient's illness, how long s/he would be away and why, etc. The Practice accepts no responsibility for any consequence that may flow from such an authorised disclosure to an employer ☐

12. A pharmaceutical or medical device company is authorised to receive the details of a negative event associated with a product must be shared ☐

13. I consent that my personal information may be used by the practice to bring new products and services to my attention and understand that I may opt out from receiving such marketing communications at any time. ☐

14. The Practice will only hold a Patients information for so long as it is legally and practically able to do so. The Patient's consent is therefore valid for the following periods, or until such time as such consent is revoked:
    - Indefinite (for situations where treatment is ongoing e.g. treatment by a General Practitioner, treatment for chronic illness, treatment where recovery period is not known etc)
    - Until revoked (for situations where treatment only pertains to a particular incident (e.g. sick leave taken, once off treatment for a specific procedure or operation etc)
    - For a particular period (e.g. for as long as I am employed by, or from [date] to [date], etc.)

    ☐

Name _____

Signature _____

Witness _____

Date _____