Patient POPI Consent

I, _____ (patient), hereby give Dr._____ consent to give the Personal Information to representatives of medical practices, insurance brokerages and relevant authoritative persons in order to assist with any reimbursement issues and to interact with my medical aid, in order to obtain medical authorization or approval of any medical procedure that my doctor has recommended ("Purpose"). Any Personal Information gathered and processed will not be used publicly without my further consent and this practice will ensure the confidentiality and integrity of my Personal Information at all times. The Personal Information will not be retained any longer than is legally required to achieve the Purpose. I will be able to revoke this consent at any time by sending a written request by registered post and on receipt of such written request; the practice will cease gathering and processing the Personal Information and de-identify any Personal Information on record.

Personal details:

Patient full names: _____
Patients ID: _____
Contact number/s: _____
Email: _____

Signature: _____ (patient) Date: _____

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