Dr Werno Knoesen
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Patient Consent to Disclosure of Information (POPI Act)

I _____ hereby give consent for my medical doctor , Dr W Knoesen , to capture and store all Personal Information relating to my health records and that of my medical aid dependants, including names, identity numbers, and other Personal Information, along with details of our medical treatment, medications, medical appointments, procedures and medical aid claims in her patient database and practice management system.

I confirm that I am authorised to give such consent on behalf of my medical aid dependants.

I understand that this Personal Information may be stored either on site at the practice, or else off-site in a secure encrypted cloud environment managed by a third party.

I understand that my doctor may need to share my Special Personal Information with healthcare service providers, for example medical aid schemes, healthcare facilities, insurers, administrators, and pharmacists, for the purpose of providing me with comprehensive, integrated health services and for conducting member checks.

I understand that from time to time my medical doctor may allow a computer specialist to access her patient database which carries my Personal Information for the purpose of updating or repairing the database. I give permission for such temporary sharing, on the understanding that the practice has signed Data Processing agreements with such third parties.

I understand that my special Personal Information will not be shared with any other third party by my medical doctor without my express, specific, prior permission.

Patient name : _____

If not patient signing, your name:
Relationship to patient:

Signed at _____on this _____ day of

_____, 20_____

Signature : _____ Witness (staff) : _____