

Protection of Personal Information (POPI) Act



Drs Schnetler, Corbett & Vennote Ingelyf Partners Incorporated

dedicated to care

Authorisation for Release of Personal Information to Third Parties

1. Details of Patient

Patient Name		Date of Birth	
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2. Details of Person Authorising Release (patient or legal guardian)

Surname						Initials												
Title	Mr	Mrs	Ms	Mx	ID No													
Home Address																		
Postal Address																		
Tel. No. (Mobile)							Email Address											
Relationship to Patient							Today's Date											

I, the undersigned, being the patient/legal guardian of the patient, hereby authorise the practice of **Drs Schnetler, Corbett and Partners Inc. (SCP Radiology)** to release/request private health information (as indicated and for the reasons below) to/from(name and ID No.)

Authorised recipient email/destination:

The purpose of the release of this information is:

Continuing Medical Care	Insurance
Legal Purposes	Personal Use
Claim from Medical Scheme	Other

The information to be released:

<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Radiology Report	<input type="checkbox"/> Other (specify)
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Type of procedure

I understand that:

1. I have the right either to give consent or refuse consent.
2. I have the right to decide that I do not want to disclose my private health information.
3. I have the right to withdraw any consent given or refuse consent at any future visit. Should this occur, I will need to inform SCP Radiology of this decision and sign another informed consent form, indicating my amended decision.

Signed		Relationship to Patient		Date
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Send completed form to info@scp.co.za