Dr Rainhard van Zyl
Orthopaedic Surgeon

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STATEMENT OF CONSENT TO DATA PROCESSING
(In terms of the provisions of the Protection of Personal Information Act)

1. I, _____ Full name(s) of patient/medical scheme member, ID number _____ ("the patient") hereby grant consent to Dr Rainhard van Zyl ("the Health Care Practitioner") and his/her/their appointer processor to process my personal data for the purpose of any or all of the undermentioned actions being the legitimate reasons for *processing and/or using my personal data*.
2. I accept that my personal information will only be utilized for the purpose it was collected, that the information will only be retained for as long as is necessary and required by law, and that I have the right to view such information at any time, as well as request correction or deletion of my personal information held by the Practice.
3. I am aware that I may withdraw my consent at any time by using the relevant Data Subject Consent Withdrawal Form.
4. I herewith consent to the Health Care Practitioner collecting and having access to my personal information.
5. I expressly consent to the Health Care Practitioner to collect and process this information for the purpose of rendering services to me as well as processing claims with medical schemes or insurance funders.
6. I expressly consent to the Health Care Practitioner handing over any outstanding accounts to debt collection third parties.
7. I expressly consent to the Health Care Practitioner and his/her/their Administrative Staff having access to my personal information contained in my health record, including any clinical notes, in order to process claims to medical schemes, issuing of documentation of any other administrative function required by my Health Care Practitioner.
8. I expressly consent to the Health Care Practitioner using my personal information to communicate with me in person / via telephone / email / video call / fax / WhatsApp / any form of social media.
9. I expressly consent that the Management Group/Society to which my Health Care Provider belongs to, be provided with such of my personal health information to enable them to render certain administrative services including coding queries, billing issues and audit assistance.
10. I expressly consent that the Health Care Practitioner may discuss any of my personal health information with any of the other members of the Clinical Team that may at any stage of my treatments be involved in providing health care services to me and to forward any such information to a referring Health Care Practitioner.

Signed by patient or guardian/representative: _____

Date: _____ **Patient/Guardian Signature**