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PATIENT INFORMED CONSENT AGREEMENT for POPI Act 4 of 2013 (POPIA), South Africa

ADDENDUM to PATIENT INFORMATION FORM(S)

AGREEMENT: The PRACTICE, DR FRANCOIS LE ROUX INC, Practice Number: 5443369, hereafter being defined in POPIA as the **Responsible Party**, employ this Agreement to ensure POPIA compliance.

CAPACITY: The person signing this FORM: PATIENT ☐ PARENT ☐ GUARANTOR ☐ GUARDIAN ☐, being defined in POPIA as the **Data Subject** - or, signing on behalf of the **Data Subject** to receive treatment / care:

Patient's name (**Data Subject**):		ID Number	
Person signing this Form:		ID Number	

SUBJECT MATTER of this Agreement: Consent for the processing and use of personal information:

Herewith the undersigned, as indicated above (CAPACITY), consents to the processing of personal information by the Responsible Party (including practice staff and authorized third parties with whom the Practice has a service or contractual relationship) and as contemplated in the Protection of Personal Information Act No 4 of 2013 (POPIA), for the following purposes to:

- Identify &/or verify the Data Subject's required details
- Treat & manage care in a dentist-patient-funder-insurance relationship (such as for pre-authorizations)
- Assess products / services of interest to the treatment
- Process data under this Agreement or for legal reasons
- Communicate with other & relevant parties inasmuch it relates to treatment and care management
- Communicate with Third Parties who contract to cover/ indemnify the patient for the costs of treatment or part thereof such as medical schemes/ administrators
- Debt collection agencies / legal services for the purposes of recovering unpaid fees
- Inform patients about Practice products, services & practice messages (such as via email / SMS / other means)
- Process information necessary & in the legitimate interest of the practice, a third party to whom the information is supplied and the patient.

Should any other reason for disclosing information be required, the Practice will first obtain your permission.

Consent by PATIENT/ PARENT/ GUARDIAN/ GUARANTOR

By signing this Agreement, in my CAPACITY to sign, of my own free will without any undue influence from any person whatsoever, I consent to this Agreement.

In the event of me being a dependant, I confirm that I have the explicit permission of my Parent / Guardian / Guarantor - and *vice versa* - to consent & herewith, I indemnify the Practice against this not being the case.

About Withholding Consent

In my CAPACITY as Patient/ Parent/ Guardian/ Guarantor, I understand it is the policy of the practice to require the completion & signing of this consent Agreement.

If you exercise your right to withhold such consent to the practice to collect & process such Personal Information, you understand & agree that in such case, the practice reserves the right not to provide dental services (except emergencies) and for which you in your CAPACITY take full responsibility and herewith indemnify the Practice.

Withdrawal of Consent

In my CAPACITY, I understand that I can withdraw this consent at any time & I undertake to inform the Practice of such withdrawal & in such case, I understand that this may affect my rights & contractual relationship with the Practice for which I take full liability and hereby indemnify the Practice should I opt for such action.

Authorized by PRACTICE

Practice Name: DR FRANCOIS LE ROUX INC,
Practice Number: 5443369
Practice Information Officer: DR FRANCOIS LE ROUX

Digitally signed: SIGNATURE

Authorized by PATIENT/ PARENT/ GUARDIAN/ GUARANTOR

Title: First Name
Surname:

Contact Number:
Email Address:

Signature: _____

Verified by Practice Administrator:

Name: PRINT NAME

Signature: SIGNATURE