



INFORMED CONSENT

PROVIDED BY PATIENT/PARENT/GUARDIAN

(“The data subject” and also “the signatory”)

In terms of
THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013 (POPIA)

OR
PERSONAL INFORMATION TO BE COLLECTED AND PROCESSED BY
DR WAYNE LETOABA PRACTICES AND AFRI HEALTH SOLUTIONS PTY LTD

CONSENT FOR THE PROCESSING AND USE OF PERSONAL INFORMATION

I understand and agree that:

- Afri Health Solutions and Dr Wayne Letoaba Practices Conduct Occupational Health and General Practitioner services to clients/patients and as part of its business functions and Afri Health Solutions and Dr Letoaba practices collect and processes Personal Information.
- The practices as health service centers and Afri Health Solutions collect, stores, uses, handles, processes, transfers, retain, archives and otherwise manages Personal Information.
- In order to discharge this duty, the Responsible Party requires my express and informed permission to collect and to process my Personal Information or that of my dependent/s who are unable to provide their own consent.
- **Purpose** I consent to Afri Health Solutions and the Dr Letoaba practices sharing my Personal Information with selected healthcare providers, medical schemes, administrators, service providers and any contracted third parties necessary for the provision of any service to me. I further agree that Personal Information provided to the practice will be used to:
 - give effect to my contractual relationship with the practice and to conduct its operations for the provision of general practice or occupational health specialist services to me and/or my dependents and for any referrals to other specialists and service providers.
 - Provide a report to the practice’s indemnity or insurance providers and the recipient will be notified of the need to protect the confidentiality of the personal information.

- comply with obligations required by any legislation affecting Afri Health Solutions, Dr Letoaba and practices.
- protect the legitimate interests of Afri Health Solutions, the practices, Dr Letoaba and or any third parties.
- store my personal health information in a secure manner in any format.
- furnish my information to medical scheme for services provided to me or my dependents and for medical research purposes.
- to access mine or my dependents medical scheme benefits.
- to provide emergency care to me/my dependents.
- retain in terms of the statutory and ethical limits.
- transfer to specialists who will access, view and store my personal health information. Afri Health Solutions and Dr Letoaba practices cannot guarantee the security or integrity of any information that I transmit to the practice online or otherwise and I agree and understand that I do this at my own risk.
- in connection with legal proceedings including debt collection;

I understand and agree that if Afri Health Solutions and the Dr Letoaba practices does not have my or my dependents consent, the practice will not be able to commence treatment and cannot share my Personal Information with any specialists/sub-contractors/other providers to optimize my healthcare treatment.

- **Withholding Consent.** I understand that I can withhold consent to the practice collecting and processing my Personal Information. I agree in this case Dr Letoaba Practices and Afri Health Solutions will not be able to provide medical services to me.

Storage of personal information. My Personal Information will be stored electronically or in hard copy in a safe and secure environment. Hard copies of Personal Information will be stored and retained safely under lock and key. After I am no longer an active patient, my Personal Information will be retained for according to the provisions of the HPCSA law or Afri Health Solutions, practice's indemnity/insurance providers require it.

- **Retention of Personal Information** The practice will not retain Personal Information for longer than is necessary and for the required purpose. The exceptions to the above principle specifically provided in POPIA are where –
 - the retention of the record is required or authorized by law;
 - the practice reasonably requires the record for lawful purposes related to its functions or activities;
 - the retention of the record is required in terms of an agreement between the practice and myself; or
 - the record is retained for historical purposes, with the practice having established appropriate safeguards against the record being used for any other purpose.
- When the Personal Information is no longer required, it shall be destroyed or deleted in a manner that prevents their reconstruction in an intelligible form.
- **Intended recipients.** I agree the intended recipients of my Personal Health Information are Afri Health Solutions, Dr Letoaba, locums, Practice staff, healthcare

providers, pathology labs, or their practice staff, medical schemes/ administrators, researchers, emergency medical service providers. Such disclosure shall always be made between Afri Health Solutions the practice and recipient to comply with strict confidentiality and security conditions as contained in POPI Act.

- **Transfer outside South Africa** I agree to the practice transferring any Personal Information outside of the borders of South Africa to its indemnity providers that has in place similar privacy laws to POPIA or the recipient is bound contractually to no lesser terms of POPIA.
- I understand that I have the right to have my Personal Information processed in accordance with the eight conditions of lawful processing of Personal Information as set out in POPIA.
- **Objection to Processing.** I understand that I have the right, to object to the practice processing my Personal Information, on reasonable grounds. On receipt of my notice of objection with reasons, Afri Health Solutions and Dr Letoaba practices shall hold any further processing of my Personal Information until my objection has been addressed, resolved, withdrawn or upheld and accepted by Afri Health Solutions and practices. If my objection is upheld, no further processing of my Personal Information shall be done. I acknowledge that practices also reserves the right to discontinue treatment.
- **Right to withdraw consent** I understand that I have the right to withdraw my consent to Afri Health Solutions and the practices processing my Personal Information at any time, provided any processing before such withdrawal or if the processing is necessary for the conclusion or performance of a contract to which I am a party will not be affected. I understand that I can revoke consent for any specific healthcare provider, or person who has access to my Personal Information. Once this information is captured and updated, my personal information will no longer be shared. I understand and agree that this may affect my treatment and I take responsibility for my decision.
- **Access** I have the right at any time to request details of any of my Personal Information that Afri Health Solutions and the practice holds, such request shall be made in writing to the administration and Information Officer of the practice.
- **Correction/Deletion** I have the right to request the practice, to correct and/or delete my Personal Information that is inaccurate, irrelevant, excessive, out of date, incomplete, misleading. That any changes to my personal information must be communicated to the practice immediately so these changes can be updated on their systems. The practice will not be liable for inaccurate information on our systems as a result of my failure to update my personal information. I have the right to request the practices and Afri Health Solutions to destroy or to delete a record of my Personal Information that the Afri Health Solutions is no longer authorized to retain in terms of any other law.
- **Correction of Personal Information** I acknowledge that whilst the practices and Afri Health Solutions will always use best endeavors to ensure that my Personal Information is reliable, it is my responsibility to advise the practice of any changes to my Personal Information, as and when these changes may occur. The practice and Afri Health Solutions will not be liable for inaccurate information on our systems as a result of my failure to inform us of my updated personal information.
- **Marketing** The practice undertakes not to distribute my Personal Information to any third party for the purpose of marketing to me third party's supplies or other products. Notwithstanding this, I agree the practice may process my Personal Information for providing me with Afri Health Solutions and practice's products / services. Should I not wish

to receive these communications, I will provide the practice with a detailed opt out, listing the type of communication that you do not wish to receive addressed to the Information Officer at info@afrihealthsolutions.org.

- I will not hold the practices and Afri Health Solutions Pty Ltd responsible for any loss (whether direct or indirect) that may arise from the use of my Personal Information.
- I may not hold the practices and Afri Health Solutions responsible for any loss that may result from the incorrect use or disclosure of the information by any healthcare provider to whom the practice has provided the Personal Information.
- to give permission for the practice and Afri Health Solutions to give my medical scheme/ or administrator details of my diagnosis and clinical information required.
- that I had an opportunity to read the terms and conditions (or they have been read to me), and I fully understand the consequences of these terms and conditions. I had sufficient opportunity to ask questions about this consent form and questions, answered to my satisfaction by the practice.
- My consent is provided of my own free will without any undue influence from any person whatsoever.
- I confirm that I have permission of my dependent(s) to give their consent, where such consent has been provided and I indemnify the practice and Afri Health Solutions against this.

The practice information Officer details are: Dr Wayne Letoaba

Email: info@afrihealthsolutions.org Tel: 083 209 1649

Patient/Parent/Guardian Name _____

Signature _____

Dependent Name and surname _____

Signature _____

Date _____

Cell No _____

E-mail address _____