SPECIALIST PHYSICIAN AND ENDOCRINOLOGIST

DR JOCELYN HELLIG

MBChB (UCT) FCP (SA) MMed Int Med (SU) Cert Endo & Metab (Phys)

DISCLOSURE OF INFORMATION TO A THIRD PARTY

CONSENT FORM

Purpose of this Form:

The completion of this form is your express permission that allows the practice of DR JOCELYN HELLIG to share your information with any third party that you have nominated. A third party is a person or an entity that has a direct relationship, or in some cases an indirect relationship with either yourself or our practice.

- ✓ Please complete all relevant sections of this form in BLOCK LETTERS.
- ✓ Please complete the form in full.
- ✓ If you have any queries, please contact our office on 0212051829 or drjocelynhellig@gmail.com.
- ✓ Please scan the completed form and return by email to: drjocelynhellig@gmail.com.
- ✓ Please include a copy of your nominated third party's identity document or passport
- ✓ Please ensure that all information is true and correct.

A. PERSONAL DETAILS OF THE PERSON GIVING CONSENT

Membership Number:

Title (Mr/Mrs/Ms/Miss

Surname

First Name (s)

B. INFORMATION THAT MAY BE PROVIDED TO THE THIRD PARTY

Biographical

- Membership Details:
- Date of Birth
- ID Number
- Postal and Email Address
- Contact Details

Medical

- Chronic Conditions
- Procedures and Diagnosis
- Hospital Procedures
- ICD 10 Codes, Tariff Codes, Nappi Codes
- Clinical Notes / Management Notes
- Scripts / list of medications

C. DETAILS OF PERSON TO WHOM CONSENT IS GIVEN (to receive the personal information as indicated in section B)

Surname:

Full Name (s):

Relationship to person giving consent:

____

ID OR Passport Number:

Home Number:

Cell Number:

Work Number:

Email:

Information requested:

☐ Biographical ☐ Medical

lease mark with an X the type of information you want the Third Party to access. Leave the others blank.

D. CONSENT

By consenting, I agree that:

1. The information specified will be shared in conjunction with stipulated specifications.
2. I am able to change or revoke my consent at any time and note that there may be slight delays during which such revocation may be unactionable.
3. I have read (or have read to me) all the terms and conditions of this form and understand what I have read or have been read to me.
4. Dr Jocelyn Hellig will provide a copy of this signed consent to you should you wish to have it.
5. I am aware of the communication channels used by the practice of Dr Jocelyn Hellig e.g., email, telephone
6. My signature under the legal declaration of this form indicates my understanding of this agreement to comply with the terms and conditions of this consent form.

E. LEGAL DECLARATION

Please read carefully before signing:

1. By signing this document, I authorise Dr Jocelyn Hellig to disclose the indicated information to the third party (parties) specified herein for the duration specified and reserve the right to revoke consent in the event of any breach of any terms or conditions of this agreement or any rules by either of the parties.
2. I understand that Dr Jocelyn Hellig accepts no liability for any loss, either direct or indirect, that may arise from any disclosure contemplated herein.
3. I acknowledge that the third party receiving the specific information from Dr Jocelyn Hellig also indemnifies Dr Jocelyn Hellig against any claims that may be made by the third parties/members against Dr Jocelyn Hellig resulting from the wrongful use or disclosure of the information by such third party.
4. I agree that once consent is given, all selected information will be given to the selected third party.
5. This consent will continue in force until expressly withdrawn by me or will be valid for the duration if specified on the form.
6. Although my dependants may have access to my personal and medical information based on my communication with them, this unfortunately does not allow my dependants access to the information from this practice. Any such information can only be supplied or disclosed to my dependants with a signed disclosure form.

Signed at ____ on ____________________________

Place **Date**

____

Signature of Personal Giving Consent

____

Full name and surname of person giving consent