Neil Hopkins Biokineticist & Associates
Gardens Virgin Active, Wembley Square,
McKenzie St., Gardens, Cape Town, South Africa
083 300 1164
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www.biokinetics.biz

CONSENT TO MANAGEMENT OF INFORMATION *(MUST BE SIGNED BY ALL PATIENTS OLDER THAN 12 YEARS)*

As part of your **consultation and ongoing treatment** your information will need to be captured, stored and possibly shared. Ethically and legally appropriate capturing, sharing and storing of information is essential in terms of the National Health Act, the Health Professions Act (and the HPCSA guidelines), the Public Access to Information Act, and the Protection of Personal Information Act. The capturing, storing and sharing of information needs to be compliant with the abovementioned legislation and you need to consent to the capturing, storing and sharing of your personal information, your medical results, your medical history, information necessary for financial statements / medical aid claims:

I, _____, the undersigned, do hereby give consent to Neil Hopkins Biokineticist to disclose information regarding my diagnosis (ICD 10 Coding), medical condition, prognosis, treatment compliance, and treatment program to the following people / institutions for the purpose of reimbursement or settlement of his / her account, and or for referral and reporting purposes: (Please initial the options you give consent to)

Medical Scheme / Funder:	_____	Doctor / medical professional	_____
Employer:	_____	Lawyer:	_____
School / Coach / Trainer:	_____	Insurance Company:	_____
Parents / children:	_____	Spouse / partner:	_____

1. I fully understand that this is a legal requirement and that I have a choice <u>not to</u> consent to such information being disclosed to any party.
2. I indemnify Neil Hopkins Biokineticist from any liability, damages or whatsoever that I may suffer as a result of this disclosure and that I will hold this practice and its associates blameless of any further disclosures and or prejudice I may suffer as a result of such disclosures.
3. I confirm that I have exercised my choice voluntarily and that this declaration and exercise of my choices was not made under duress.

_____ **Date:** _____ **/**_____**/**_____

SIGNED: PATIENT / GUARDIAN IF PATIENT IS YOUNGER THAN 12.

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CONSENT TO DIGITAL COMMUNICATION *(MUST BE SIGNED BY ALL PATIENTS OLDER THAN 12 YEARS)*

As part of your **consultation and ongoing treatment** it may be required to communicate using digital / electronic / distance / non-face-to-face / telemedicine platforms as a method of communication. It is important to acknowledge that face-to-face care is the best form of care, however it is not always practical or possible.

Patient-practitioner communication via digital / electronic / distance / non-face-to-face / telemedicine needs to be compliant with the National Health Act, the Health Professions Act (and the HPCSA guidelines), the Public Access to Information Act, and the Protection of Personal Information Act. Ethically and legally appropriate capturing, sharing and storing of information still applies to patient-practitioner communication via digital / electronic / distance / non-face-to-face / telemedicine platforms. Your patient information will need to be captured, stored and possibly shared using third-party platforms (Gmail, WhatsApp, Skype, DropBox, Xero, etc.). The PAIA and POPIa require that these third-party platforms are located in countries that have similar or better privacy legislation than South Africa.

The capturing, storing and sharing of information needs to be compliant with the abovementioned legislation and you need to consent to the use of third-party platforms involved in the digital / electronic / distance / non-face-to-face / telemedicine correspondence. These third-party platforms may play an indirect role in the capturing, storing and sharing of your personal information, your medical results, your medical history, information necessary for financial statements / medical aid claims.

1. I fully understand that this is a legal requirement and that I have a choice not to consent to such information being disclosed to / via any third-party.
2. I indemnify Neil Hopkins Biokineticist from any liability, damages or whatsoever that I may suffer as a result of this disclosure and that I will hold this practice and its associates blameless of any further disclosures and or prejudice I may suffer as a result of such disclosures.
3. I confirm that I have exercised my choice voluntarily and that this declaration and exercise of my choices was not made under duress.

_____ **Date:** _____ **/**_____**/**_____

SIGNED: PATIENT / GUARDIAN IF PATIENT IS YOUNGER THAN 12.