

PR No 3801543

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In compliance with the Protection Of Personal Information Bill (Act 2013)



CONSENT TO TRANSFER (SEND/RECEIVE) IMAGES/REPORTS OR REFERRAL AND MOTIVATION LETTERS TO A 3rd PARTY, MEDICAL AID SCHEME OR LEGAL ENTITY

PATIENT / LEGAL GUARDIAN / PARENT OF PATIENT AUTHORISATION

I, _____

ID Number: _____

authorise Cape Radiology, practice number 3801543, to release my and/or my legal ward's, medical images, medical reports, referral and motivation letters to:

Recipient name and contact number	
Recipient email address	
Medical Aid/Legal Entity Name	
Member number	
Patient details of which as stipulated below	
Patient Name	
Patient ID Number or date of birth	
Relation to Patient	
Study type and date of study	
Account (accession) Number	
*clearly specify each account number	

I understand that the above-mentioned information will be transferred (sent/received) electronically to the specified recipient and that my consent is voluntary and can be withdrawn at any time.

I confirm that by transmitting the above-mentioned information to the person indicated above Cape Radiology is not in breach of my patient confidentiality in accordance with the POPI Act of 2013. I hereby indemnify Cape Radiology from any claim, damages or costs arising, directly or indirectly, in connection with the transmission of the above medical information.

Signature of Patient/Legal Guardian/Parent of Patient _____

Who warrants that he/she is duly authorized to sign on behalf of the patient where applicable.

Date: _____

FOR INTERNAL USE:

Requested by	Date
Approved by Management	Attached to Patient record