PATIENT STATEMENT OF CONSENT FORM

I, the undersigned:
Full Name: _____

Identity Number/Date of Birth/Passport Number: _____

Patient or parent/legal guardian of the Patient (as applicable) (the **"Patient"**), **hereby give my consent** for all doctors, employees, directors, radiographers, consultants, researchers etc. of **Parklane Radiology (Proprietary) Limited Registration No**: **2013/116063/07** trading as *Parklane Radiology* at Parklane Hospital, Parktown Gauteng and Hillcrest Medical Centre at Hillcrest KZN, *Intercare Gonubie* at East London ,*Kempton Park Mammography* at Kempton Park Gauteng & *Women's Imaging Centre* in Parktown, Gauteng (collectively referred to as **the "Practice"**) to **Collect, Send, Process** or **Retrieve my/ the Patient's personal information** (as defined in the Protection of Personal Information Act No 4 of 2013 (**"POPIA"**) (**"Personal Information"**) that includes but is not limited to: full name(s), identity number(s), birth date(s), cell phone number(s), email address(es), physical address(es), postal address(es), occupation, employer details, medicine(s), treatment, HIV status and all further confidential **Medical Information and Medical History** pertaining to myself **("Medical Information")** from referring doctors and specialists, including but not limited to all medical reports, MRI reports, all radiology imaging, etc. pertaining to the Patient and/or myself to or from the below mentioned **Third Parties'** in connection with my or the Patient's care, to **enable** the **Practice** to **provide** the **necessary health services, medical** and **administration facilities ("Services")** to me and/or the Patient:

Third Parties:

1. All doctors the Practice engages with, in order to provide the Services (i.e., general medical practitioners, gynaecologists, anaesthetists, surgeons, physicians oncologists, any and all radiology practices situated in South Africa and internationally any medical officers, researchers and any other medical specialists.
2. All local and international radiographers.
3. SIE Solutions.
4. Afrihost.
5. Watchguard.
6. Escan.
7. All imaging viewing platforms including but not limited to PACS, Carestream, XERO etc.
8. Cryanic.
9. All Hospitals situated in South Africa.
10. All South African Medical Aid Schemes.
11. All local laboratories.
12. Any foreign laboratories.
13. Any international Medical Aids.

14. Any Medical Insurance Companies
15. Any of the Practice's duly authorized Operators (as defined in POPIA).
16. The Practice's auditors and financial consultants.
17. Any debt recovery companies & credit bureau.
18. Any attorneys in my and/or the Patient's jurisdiction, if any litigation pertaining to me and/or the Patient, is instituted by the Practice or myself and/or the Patient.

(**"Third Parties"**)

(i) I understand that the aforementioned information is about me, or the Patient of whom I am the parent or legal guardian (of a child, incapacitated, or elderly person).

(ii) I understand that the aforementioned Personal Information and Medical Information will be collected by the Practice in terms of the rules and regulations set out in POPIA, and other relevant legislation.

(iii) I understand that the aforementioned Personal Information and Medical Information, will be sent to or retrieved and/or Processed (as defined in POPIA) in accordance with the rules and regulations set out in POPIA by the Practice and any Third Parties, as requested from time to time.

(iv) My consent is voluntary, and I understand that I can withdraw it at any time.

(v) I understand that the Personal Information will be transferred electronically and/or Processed (as defined in POPIA) in accordance with the regulations of POPIA and any other applicable legislation.

(vi) I understand that the Practice will not be able to render the necessary Services to me and/or the Patient, if I don't provide the necessary Personal Information to it or its employees, directors, doctors, trustees, researchers, consultants, doctors, specialists and Third Parties.

(vii) My Personal Information and Medical Information will be retained indefinitely for medical, statistical and academic research purposes. If it is not required for the aforesaid purpose(s), it will be destroyed in accordance with the rules set out in POPIA and the rules of the applicable governing medical profession(s) and/or their successors and the guidelines set out by the Health Professions Council of South Africa (**"HPCSA"**) that require us to retain your Personal Information and Medical Information for a period of at least **5 (five)** years.

(viii) I understand that I have the right to access my Personal Information and Medical Information at any time in accordance with the relevant provisions contained in POPI and the Promotion of Access to Information Act No 2 of 2000 (**"PAIA"**) and that I have the right to rectify any details with the Practice at any time.

(ix) I understand that I have the right to lodge a complaint to the Information Regulator at **JD House, 27 Stiemens Street, Braamfontein, Johannesburg, 2001 or via email: complaints.IR@justice.gov.za** in accordance with Section 18 of POPIA.

Indemnity:

By signing this Consent Form, I am allowing the Practice and any of the Third parties (*as listed above*), access to my/the Patient's (i) confidential Personal Information and (ii) Medical Information (as set out above). **By giving my consent**, **I hereby indemnify the Practice** for any consequences arising from the **unauthorized access of my/the Patient's reports** and/or any of my/the Patient's Personal Information (as defined in POPIA) and hold the Practice harmless **against any liability therefrom**) **to the extent permissible under POPIA,** suffered by myself and/or the Patient as a result of any of the Third Parties' failure to comply with their statutory obligations contained under POPIA and/or any willful and/or negligent acts or omissions of any Third Party, their employees, contractors, agents or any duly authorized Operators (as defined in POPIA).

SIGNATURE _____

NAME: _____

DATE: _____

WITNESS_____