DR LATIEFA VINOOS
OBSTETRICIAN / GYNAECOLOGIST

CONSENT TO DATA PROCESSING

I, the undersigned:
Full Names:_____
ID Number:_____

Grant consent to the practice of Dr Latiefa Vinoos and to its operator, Xpedient Medical (Pty) Ltd .

I acknowledge that my personal information needs to be processed by the Practice and therefore grant the following consent:
I acknowledge and accept that the Practice will during the course of rendering services to me, collect and have access to my personal information, including information relating to my race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language, identifying number, symbol, e-mail address, physical address, telephone number, location information, online identifier and my biometric information.
I acknowledge and accept that my health information, as Special Personal Information will be collected and processed by the Practice.
I grant my express consent for Practice to collect and process this information for the purpose of rendering services to me as well as processing claims with medical schemes or insurance funders as well as, if necessary, the handing over of outstanding accounts to debt collection companies/ attorneys.
Administrative staff employed at the Practice may be granted access to my personal information contained in my health record, including any clinical notes, in order to process claims to medical schemes, issuing of documentation or any other administrative function required by the Practice.
The Practice makes use of a medical billing service company, namely Xpedient Medical (Pty) Ltd and I grant my consent to the processing of my medical information by Xpedient Medical and its employees as is required to process claims with medical schemes.
I accept that my personal information will be accessed and processed by my medical scheme and/or health insurer and grant the Practice and Xpedient Medical consent to transmit that information as required to process any claims.
I accept that my personal information will only be utilized for the purpose it was collected, that the information will only be retained for as long as is necessary and required by law, and that I have the right to view such information at any time, as well as request correction or deletion of my personal Information held by the Practice.
I am aware that I may withdraw my consent at any time by using the Data Subject Consent Withdrawal Form, which may be obtained from the Practice.

SGNED AT _____ ON THIS _____DAY OF _____ 20_____

Name: _____

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