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**PROTECTION OF PERSONAL INFORMATION ACT (POPIA) CONSENT FORM**

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| **PATIENT INFORMATION** Full Name: Date of Birth: Identity Number: Contact Number: Email Address: Physical Address:  **PURPOSE OF COLLECTING PERSONAL INFORMATION** As a patient of Dr Lize Wolfaardt, Counselling Psychologist, your personal and medical information will be collected and processed to provide you with care, ensure proper records, and for billing and administrative purposes. Completion of this document confirms that your personal information will be handled in accordance with the provisions of the Protection of Personal Information Act, 2013 (POPIA).  **PERSONAL INFORMATION COLLECTION** The personal information that can be collected includes, but is not limited to: - Personal details – name; identity number; contact details and address. - Medical history – health information; diagnosis; treatment history and other relevant health data. - Payment details – medical aid details; insurance and billing information.  **USE OF PERSONAL INFORMATION** The personal information collected will be used for the following purposes: - Providing psychological care and advice. - Maintaining health records. - Submitting claims to medical aids or insurance. - Administrative purposes, including scheduling appointments; billing and communication. - Compliance with legal and ethical requirements as mandated by the Health Professions Council of South Africa (HPCSA).  **STORAGE AND PROTECTION OF INFORMATION** Your personal information will be stored securely both in physical and electronic formats.  Dr Lize Wolfaardt, Counselling Psychologist, and authorized staff are responsible for ensuring your  information is protected from unauthorized access, disclosure, alteration or destruction. | **SHARING OF PERSONAL INFORMATION** Your personal information may be shared with the following entities only when necessary for the purposes of providing your care, or as provided by law: - Medical Aid and other health insurance companies for billing and claims purposes. - Other healthcare providers involved in your treatment (EG: hospitals; radiologists; specialists). - Regulatory bodies or government authorities as required by law.  **YOUR RIGHTS** - Access – you have the right to access the personal information we hold about you. - Correction – you have the right to request correction of inaccurate or incomplete information. - Withdrawal of Consent – you have the right to withdraw your consent to the processing of your personal information at any time, subject to the legal or contractual restrictions. - Deletion – you may request the deletion of your personal information subject to the legal obligations to retain such information.  **CONSENT TO PROCESSING OF PERSONAL INFORMATION** By signing this document you consent to the collection; processing and storage of your personal information as detailed above and in accordance with the requirements of the Protection of Personal Information Act (POPIA).  **PATIENT ACKNOWLEDGMENT AND CONSENT** I, the undersigned, have freely and without duress, read and understood the information contained in this document regarding the collection, use and protection of my personal information. I consent to these terms and conditions regarding and in accordance with the Protection of Personal Information Act (POPIA).  Full Name: Date: Signature:  IN THE CASE OF MINORS: Guardian Name: Contact Number: Date: Signature: |

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