

LIZANÉ VAN GRAAN

CLINICAL PSYCHOLOGIST

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CONSENT TO DISCLOSURE

(one copy to be stored in the patient's file & one copy to be given to the patient)

Patient Details /

The Parent / Legal Guardian of a child younger than 12 years of age (if applicable) /

A Child 12 years or older (if applicable)

Name & Surname:

ID Number:

Tel No:

E-mail Address:

I, _____ hereby authorise, freely and voluntarily and with knowledge of the implications of such consent, the Practice to disclose the specific information outlined herein to the entities / person(s) mentioned and to the extent identified herein.

Reason why information is to be disclosed (please select the applicable purpose):

| | | | |
|--|--|--|--|
| Claim for Medical Scheme | | Insurance Purposes | |
| Clinical data for Medical Aid PMB | | Personal Use | |
| Employer / School records | | Legal Purposes | |
| Disability Forms | | To receive updates on well-being of patient: <input type="checkbox"/> Doctor <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Educators | |
| Attendance of parent/spouse/friend/family member in consultation/procedure | | Other (please specify): | |

The information to be disclosed (please select the applicable information):

| | | | |
|--------------------------------|--|-------------------------|--|
| Clinical Notes | | Sick Certificate | |
| Psycho-Educational Assessments | | Medico-legal Report | |
| Consultation attendance | | Other (please specify): | |
| Patient's File | | | |
| Medical Report | | | |

To whom may this information be released (please select the applicable purpose):

Name & Surname:

ID Number: _____ Tel No: _____ E-mail Address: _____

Relationship to patient: _____ For how long is this consent valid? _____

Patients can withdraw this consent at any time bearing in mind that withdrawal may not be possible in certain instances without negatively affecting patients' rights and contractual relationships, for which patient takes full liability and indemnifies the Practice.

Patient Name

Signature

Signed at: _____ / _____ /20____

ARMANSIS MEDICAL CENTRE
12 LUDORF STREET
BRITS, 0250

B.A. HONS (PSYCH)(NWU) / B.A. HONS – PRACTICAL PSYCHOMETRY
M.A. CLINICAL PSYCHOLOGY (UL)
CLINICAL PSYCHOLOGIST &
INDEPENDENT PSYCHOMETRIST

PS0133892 PR0724394 PMT0081876 PR0636282