Permission to make certain information available to a third party

Contact details
Tel: 0860 116 116 • PO Box 652509, Benmore 2010 • www.yourremedi.co.za

Who we are

Remedi Medical Aid Scheme (referred to as 'Remedi'), registration number 1430, is the medical scheme that you are currently a member of. This is a not-for-profit organisation, registered with the Council for Medical Schemes (CMS).

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Remedi and takes care of the administration of your membership.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. To avoid administration delays, please ensure this application is completed in full and signed by both the doctor and the member (or their proxy).
3. Please return the completed application form to us by email to **consent@yourremedi.co.za**.
4. If you wish to appeal a decision or if you have any questions, you may call our call centre.
5. Please specify the type of information that each third party may have access to and for how long the access should be valid. If you don't specify a date, we will assume the permission to be valid from the date of signature, in section 4 of this form, to continue until you revoke the permission in writing.
6. For more information about how and why we use your information, please view our Privacy Statement: **https://www.yourremedi.co.za/wcm/medical-schemes/remedi/assets/legal/privacy-statement-for-remedi-medical-aid-scheme.pdf**

By signing this application, you confirm that the information provided is true and correct.

1. Main member details

Membership number

ID or passport number

Member's name

Member's surname

2. About the third party (to whom we may give specified information)

2.1. **Your financial adviser** ☐

Your financial adviser is your appointed financial adviser, or your employer's appointed financial adviser, who is on record and works at your or your employer's appointed intermediary house. This financial adviser may change occasionally. This means the new financial adviser will have access to the information you make available. If you want to give permission to only a specific person, please complete the specific third party section of this form.

Financial Adviser number

Surname

First name(s) (as per identity document)

Third Party **Please tick the third party to which you want to make information available**

Make all of the below available ☐

	Financial Adviser	Financial Adviser house	Employer contact person		
Biographical information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Benefit information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Financial information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y

Third Party	Please tick the third party to which you want to make information available				
Make all of the below available	☐				
Medical information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y

(Refer to table 1 on page 4 for examples of these types of information).

2.2**. Financial Adviser house** ☐

An intermediary house is a group of financial advisers who conduct their business and give advice under one business name.

Financial Adviser house	
Financial Adviser house name	

Third Party	Please tick the third party to which you want to make information available				
Make all of the below available	☐				
	Financial Adviser	Financial Adviser house	Employer contact person		
Biographical information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Benefit information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Financial information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Medical information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y

(Refer to table 1 on page 4 for examples of these types of information).

2.3. **Your employer contact person** ☐

Your employer contact person is the contact person or representative where you work. This contact person or representative may change occasionally. This means a new contact person or representative may have access to the information you make available. Your permission only applies to the contact person at your current employer. If you change employers, this permission will end. If you want to give permission to only a specific person and not the employer contact person in general, please complete the specific third party section of this form.

Title	
Surname	
First name(s) (as per identity document)	
ID or passport number	

Third Party	Please tick the third party to which you want to make information available				
Make all of the below available	☐				
	Financial Adviser	Financial Adviser house	Employer contact person		
Biographical information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Benefit information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Financial information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Medical information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y

(Refer to table 1 on page 4 for examples of these types of information).

2.4. **Your doctor** ☐

BHF Practice number

Doctor's first name and surname

Please specify the type of information that your financial adviser, financial adviser house and/or employer contact may have access to and for how long the access should be valid. If you don't specify a date, we will assume the permission to be valid from the date of signature, in section 4 of this form, to continue until you revoke the permission in writing.

Your doctor

Make all of the below available			
Biographical information		D D M M Y Y Y Y	D D M M Y Y Y Y
Benefit information		D D M M Y Y Y Y	D D M M Y Y Y Y
Financial information		D D M M Y Y Y Y	D D M M Y Y Y Y
Medical information (Including Health Record containing pathology and radiology results and may include HIV-related information)		D D M M Y Y Y Y	D D M M Y Y Y Y

(Refer to table 1 on page 4 for examples of these types of information).

**Please refer to the specific terms and conditions section under 'Discovery HealthID application consent' on the final page of this form.*

2.5. **Specific third party 1**

You give permission to make information available to the third party specified below.

Title

Surname

First name(s) (as per identity document)

ID or passport number

Phone number

Email address

2.6. **Specific third party 2**

You give permission to make information available to the third party specified below.

Title

Surname

First name(s) (as per identity document)

ID number

Phone number

Email address

2.7. **Specific third party 3**

You give permission to make information available to the third party specified below.

Title

Surname

First name(s) (as per identity document)

ID number

Phone number

Email address

3. About the information we may provide to the third party

Please specify the type of information each specific third party may have access to and for how long the access should be valid. Should you not specify a date, we will assume the permission to be valid from the date of signature, in section 4 of this form, to continue until you revoke the permission in writing.

Examples of the type of information that we can make available to a third party are listed in the table below:

Third Party	**Please tick the third party to which you wish to make information available**				
Make all of the below available	☐				
	Specific party 1	**Specific party 2**	**Specific party 3**	**From**	**To**
Biographic information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Benefit information	☐	☐	☐	D M M Y Y Y Y	D M M Y Y Y Y
Financial information	☐	☐	☐	D M M Y Y Y Y	D M M Y Y Y Y
Medical information	☐	☐	☐	D M M Y Y Y Y	D M M Y Y Y Y

Table 1

Examples of biographic information	**Examples of benefit information**	**Examples of Financial information**	**Examples of Medical information**
• Membership number • Date of birth • ID number • Postal and e-mail address • Physical address • Telephone numbers	• Plan type • Medical Savings Account amounts available • Medical Savings Account choice: Scheme Rate or Cost • Current Medical Savings Account spent • Limits • Waiting period details • Self-payment Gap • Above Threshold Benefit • Wellness partner activation/ status / gym • Wellness partner benefit usage • Wellness partner Points Monitor	• Medical scheme tax certificate and tax summary • Banking details • Total contribution and breakdown • Wellness partner rewards received	• Indicator of chronic condition/s • Prescribed Minimum Benefit chronic condition details • Confirmation of claims paid (excluding amounts and origin of payments) • Claims transaction history, Hospital procedures, Procedure codes • Procedures done in doctors' rooms paid from Hospital Benefit **Doctors only** Electronic Health Record (including pathology and radiology results and may include HIV-related information)

4. New Terms and conditions

4.1. This document provides permission to Remedi, and its outsourced service providers, including the administrator and wellness partner, to make certain information available to the named third party or third parties selected in this form and reserves the right to revoke this consent if there is a breach of any terms and conditions of this agreement or any rules by either of the parties.

4.2. You agree that by making this information available, Remedi, and its outsourced service providers, including the administrator and wellness partner, are not responsible for any loss, whether direct, indirect or as a result of disclosing the information.

4.3. You agree that the named third parties receiving this information may not hold Remedi, and its outsourced service providers, including the administrator and wellness partner, responsible for any claims that result from the wrongful use or disclosure of the information by the named third parties.

4.4. You agree that once you have provided permission, Remedi, and its outsourced service providers, including the administrator and wellness partner, may give all the information that falls under the selected type of information to the named third parties.

4.5. This permission will end on the dates specified in section 2 and 3 of this form or when your employer contract ends (should your relationship with Remedi, and its outsourced service providers, including the administrator and wellness partner, be through your employer). You agree that should you not have given an expiry date in section 2 and 3 of this form, the permission will only end on your specific instruction in writing (or when the purpose of the permission has been served). Any 3rd party consent expires on death.

4.6. Remedi, and its outsourced service providers, including the administrator and wellness partner, will only share the personal, financial and medical information for you or your beneficiaries should it be requested by a third party to which you have already provided consent for disclosure and the parties with which Remedi, and its outsourced service providers, including the administrator and wellness partner, share the information agree to keep the information confidential. Should Remedi, and its outsourced service providers, including the administrator and wellness partner, wish to share your information for any other reason, we will do so only with your express consent.

5. Consent to use the Remedi Electronic Health Record application. * (refer to 2.2)

Definitions

“Applicable law” includes all these:

- the Promotion of Access to Information Act 2 of 2000
- the Electronic Communications and Transactions Act 25 of 2002 (as amended)
- the Protection of Personal Information Act 4 of 2013
- the Consumer Protection Act 68 of 2008
- the Medical Schemes Act 131 of 1998 (as amended)
- the National Health Act 61 of 2003
- the Children’s Act 38 of 2005
- the Choice on Termination of Pregnancy Act 92 of 1996
- Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act, 1974 published as GNR 717, dated 4 August 2006 in the Government Gazette (“the Ethical Rules”)
- All applicable guidelines published in General Ethical Guidelines for the Health Care Professions as published by the Health Professions Council of South Africa (“the HPCSA guidelines”).
  “Electronic Health Record” (or EHR) is a regularly updated summary of all information (also referred to as “my information”) that is accessible and made available through the Remedi Medical Aid Scheme Electronic Health Record application.
  “My information” refers to all personal, other and possibly sensitive medical, clinical or claim information (recorded in the EHR) and includes:
- All existing and newly diagnosed chronic conditions
- Chronic Illness Benefit and Health Plan information
- Certain biographical details
- Medical information that healthcare providers send to the Scheme and its administrator
- All results, including pathology and radiology (if any), which may also include information about HIV or AIDS, sexually transmitted diseases and pregnancy or its termination.

Acknowledgement

I acknowledge that –

- Remedi's administrator has developed an application (“Electronic Health Record”) medical practitioners can use to access my information recorded in my Electronic Health Record (EHR).
- The purpose of Electronic Health Record is to support and enable quality clinical care to members and to help reduce the administrative burden on medical practitioners accessing my information.
- Only medical practitioners who have subscribed to and are authorised to use my Electronic Health Record and its features (“authorised medical practitioners”) can access my information.
- All authorised medical practitioners who treat me from time to time may only request and access my information through the EHR if they have my consent.
- Once I have granted consent, any authorised medical practitioners who I may consult from time to time and who have my consent may access all my information recorded in my EHR including details of consultations with other medical practitioners I may have consulted before.

I may at any time change or revoke my consent by formally letting Remedi know of my decision. In this case, Electronic Health Record will grant authorised medical practitioners access to my information only up to the date I change or revoke my consent and will not make my information available to any authorised medical practitioners from then on. By granting my consent, I provide Remedi permission to share my information (through my EHR) with my authorised medical practitioners to assist in making informed clinical decisions.
I understand that once Remedi has shared my information with authorised medical practitioners, Remedi has no further control over this information and will not be accountable for its safeguarding. I also understand that the authorised medical practitioners have confirmed to the Scheme's administrator that they will treat my information as confidential and in line with applicable laws.
I note that Remedi will, as required by and in adhering to applicable laws, protect and maintain the confidentiality of my information.

Consent

5.1. By consenting, I agree to –

5.1.1. My information being made available to authorised medical practitioners through Electronic Health Record for the purposes outlined here.

5.1.2. Remedi's administrator receiving my information directly from any healthcare provider and making this available through my Electronic Health Record.

5.2. I am entitled to change or revoke my consent at any time. When I revoke my consent, medical practitioners will no longer be able to access my information.

5.3. The consent I provide (as set out in this form) is valid from the date and time when I give consent and will continue until I change or revoke my consent as explained in point 2.

5.4. I agree that by making this information available, the Scheme's administrator will not be responsible for any loss or damage (whether direct or indirect) that may arise from the use of this information, other than where it is due to or attributable to grossly negligent or fraudulent conduct by the Scheme and / or its administrator.

5.5. I provide permission for my authorised medical practitioners to provide the Scheme and the administrator with my diagnosis and other relevant clinical information to review applications for the Chronic Illness Benefit. For the Chronic Illness Benefit, I understand that –

5.5.1. Funding from the Chronic Illness Benefit depends on meeting benefit entry requirements as determined by Remedi.

5.5.2. It provides cover for disease modifying therapy only, which means that not all medicines for a listed condition are automatically covered or funded.

5.5.3. By registering, I agree that my condition may be subject to disease management interventions and periodic review and that this requires giving both Remedi and my authorised medical practitioners access to my information.

5.5.4. Funding for medication will only be provided from when Remedi receives and approves an application form that is completed in full.

5.5.5. I may need to send an updated or new application form, if Remedi asks for this.

5.6. I have had an opportunity to read (or have read to me) and I am aware of and fully understand all the terms, conditions and consequences of providing my consent.

5.7. I have had sufficient opportunity to ask questions about this consent form and have had these questions, if any, answered to my satisfaction by Remedi and/or its administrator.

5.8. I have been made aware that the full terms and conditions can be accessed on www.yourremedi.co.za or by calling 0860 116 116 and that Remedi will provide me with a copy of this consent form on my request.

5.9. My consent to all the terms and conditions of Electronic Health Record is provided of my own free will without any undue influence from any person whatsoever.

I indicate my full understanding and agreement to consent to use Remedi Electronic Health Record.

My signature below indicates my understanding of an agreement to comply with the terms of this consent form.

Signed at (town or city) on D D M M Y Y Y Y

Please print name

Signature of person providing permission