Confidential Patient Consent Form for Telephonic/Internet Registration

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The HIV programme does not dispense medication - Please fax this completed form to 0800 600 773 or email it to polmedhiv@medscheme.co.za

Principal (Main) Member Details

First Name _____ Surname _____

Medical Scheme _____ Gender Male Female

Membership No. _____ Option/Plan _____

Patient Details

First Name _____ Surname _____

Dependent Code _____ Gender Male Female

ID Number _____ Date of birth D D M M Y Y Y Y

Treatment Support is a vital part of the HIV programme. Contact details must be supplied to enable us to provide you with this support.

Confidential Email _____

Postal Address for Confidential Mail _____

Postal Code _____ Telephone (Work) _____

Fax _____ Telephone (Home) _____

Preferred form of Communication Email Fax Post Cellphone _____

Doctor Details

Surname & Initials _____ Practice No. _____

Email Address _____ Telephone _____

Postal Address _____

Postal Code _____ Cellphone _____

Preferred form of Communication Email Fax Post Fax _____

I understand that all personal clinical information supplied to the HIV programme will be used to determine access to specific benefits for people with HIV infection. The HIV programme will take all reasonable steps to maintain confidentiality. The programme's medical staff will review this information in order to make recommendations regarding the provision of these benefits. Your doctor, however, retains responsibility for your care, irrespective of the benefits so authorised. I/we therefore, authorise any doctor, hospital, clinic, laboratory and/or medical facility in possession of any medical information regarding myself, the applicant or any dependant (also newly born baby), to provide the HIV programme with information that it may require. I warrant that the information in this application form is correct. I acknowledge that completion of the application form does not automatically entitle me to any benefits and that acceptance to the programme is within the sole discretion of the HIV programme. I acknowledge that I am familiar with the conditions and benefits of the programme, notwithstanding representation by any other party; and agree to abide by and undertake to familiarize myself with the rules of the programme as amended from time to time. I acknowledge that benefits authorised by the HIV programme are subject to scheme rules and that non adherence to the programme could result in my benefits from this programme being cancelled. I acknowledge that I will be responsible for any co-payments as per scheme rules or payment for any medication and/or investigations not authorised by the HIV programme. I understand that acceptance onto the HIV programme means that an HIV treatment support counsellor will contact me. I herewith authorise the HIV programme and its agents/medical staff to disclose the medical information relevant to my HIV infection to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

Patient's signature _____ Date D D M M Y Y Y Y

Doctor's signature _____