

Permission to make certain information available to a third party

Contact details

Tel: 0860 002 133 • www.sabmas.co.za

By completing this form, you allow us to share your information with any third party you nominate. A third party is any person or entity that has a relationship with SAB Medical Aid, including its administrator (currently Discovery Health (Pty) Ltd.) as well as those entities who do not have a direct relationship with SAB Medical Aid.

Who we are

SAB Medical Aid (referred to as 'the Scheme'), registration number 1209, is a not-for-profit organisation, registered with the Council for Medical Schemes. 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 responsible for the administration of your membership on behalf of the Scheme.

How to complete this form

1. Please use one letter per block, complete the form with black ink and print clearly. Alternatively, complete it digitally.
2. To avoid administrative delays, please make sure this form is completed in full.
3. Please email the completed and signed form to consent@sabmas.co.za.
4. Incomplete forms will not be considered as valid consent.
5. Provide a copy of your nominated third party's identity document or valid passport.
If your nominated third party has not previously given SABMAS a copy of their identity document, please submit it with this form.
If we cannot identify your nominated third party, we cannot complete the request for this (applicable to section 2.3, 2.4 and 2.5).
6. 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.
7. For more information about how and why we use your information, please view our Privacy Statement:
<https://www.sabmas.co.za/portal/sabmas/security-and-fraud>

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

1. Beneficiary details

Surname	
First name(s) (as per identity document)	
ID or passport number	
Date of birth	
Telephone	
Email	

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

2.1. 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 which you make information available

Make all of the below available ☐

	Employer contact person	Effective from	Effective to
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).

2.2. Your doctor☐

BHF Practice number

Doctor's first name and surname

Your doctorMake all of the below available ☐

	Doctor	Effective from	Effective to
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.

2.3. Specific third party one☐

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

Email

Telephone

2.4. Specific third party two☐

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

Email

Telephone

2.5. Specific third party three ☐

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

Email

Telephone

3. About the information we may give to the specified 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. 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.

Third party

Please tick which type of information should be made available

Make all of the below available

☐

Specific third	Specific third party one	Specific third party two	Specific third party three	Date from	Date to
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

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

Examples of biographic information	Examples of benefit information	Examples of financial information	Examples of medical information
Membership number	Option type	Medical aid tax certificate and tax reports	Indicator of chronic condition
Date of birth	Medical Savings Account balance	Banking details	Prescribed Minimum Benefit chronic conditions details
ID number	Medical Savings Account choice: Scheme Rate or Cost	Total contribution and breakdown	Confirmation of claims paid (excluding amounts and origin of payments)
Postal and email address	Current Medical Savings Account spent		Claims transaction history
Physical address	Limits		Hospital procedures
Telephone numbers	Waiting period details		Procedure codes
	Option Exclusions		Procedures done in doctors' rooms paid from Hospital Benefit
			Doctors only: Health Record (including pathology and radiology results and may include HIV-related information)

4. Agreement to the terms and conditions

- 4.1. This document provides SAB Medical Aid, and its outsourced service providers, including the Administrator, permission 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, SAB Medical Aid, and its outsourced service providers, including the Administrator, 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 SAB Medical Aid, and its outsourced service providers, including the Administrator, 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, SAB Medical Aid, and its outsourced service providers, including the Administrator, 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 SAB Medical Aid, and its outsourced service providers, including the Administrator, be through your employer). You agree that, should you have not 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 third party consent expires on death.**
- 4.6. SAB Medical Aid, and its outsourced service providers — including the Administrator — will only share your personal, financial, and medical information (including that of your dependants or beneficiaries) with third parties if you have already provided consent for such disclosure. All parties receiving this information must agree to keep it confidential. If SAB Medical Aid or its outsourced service providers — including the Administrator — wish to share your information for any other reason, they will do so only with your explicit consent.

Consent to use the Discovery HealthID application

I understand that once SAB Medical Aid has shared my information with authorised medical practitioners, SAB Medical Aid 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 Administrator that they will treat my information as confidential and in line with applicable laws. I note that SAB Medical Aid will, as required by and in adhering to applicable laws, protect and maintain the confidentiality of my information.

Consent

1. By consenting, I agree to –
 - 1.1. My information being made available to authorised medical practitioners through HealthID for the purposes outlined here.
 - 1.2. SAB Medical Aid's Administrator receiving my information directly from any healthcare professional and making this available through HealthID.
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.
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.
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. 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.
6. I have had sufficient opportunity to ask questions about this consent form and have had these questions, if any, answered to my satisfaction by SAB Medical Aid and/or its Administrator.
7. I have been made aware that the full terms and conditions can be accessed on www.sabmas.co.za or by calling **0860 002 133** and that SAB Medical Aid will provide me with a copy of this consent form on my request.
8. My consent to all the terms and conditions of HealthID is provided of my own free will without any undue influence from any person whatsoever.
9. I agree that if I have not given an expiry date in section 2 and 3 of this form, the permission will only end in your specific instruction in writing (or when the purpose of the permission has been served). Any 3rd party consent expires on death.

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 HealthID 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

SABPMC001

- Chronic Benefit and benefit option information
- Certain biographical details
- Medical information that healthcare professionals send to Discovery Health (Pty) Ltd and the Scheme.
- 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 –

- SAB Medical Aid’s Administrator has developed an application (HealthID) medical practitioners can use to access my information recorded in my Electronic Health Record (EHR)
 - The purpose of HealthID 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 HealthID 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 SAB Medical Aid know of my decision. In this case, HealthID 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 SAB Medical Aid permission to share my information (through my EHR) with my authorised medical practitioners to assist in making informed clinical decisions.
- I indicate my full understanding and agreement to consent to use HealthID

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
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Please print name

Signature of person giving permission