FORM: record of disclosure of confidential information

(keep on file of patient or with other records to show that matter was considered and consent obtained should anyone raise a complaint / dispute on the disclosure)

Person name and surname / company name: _____

Justification for disclosure:
☐ Patient or authorized person provided written consent of person whose information it is or who is mandated to consent *(please attach consent form* (document nr 5*))*:

☐ Authorized by a law, the specific law or section in the law, which law is called: _____

_____

Who is requesting the information?

☐ Person whose information it is
☐ A medical scheme / administrator
☐ A family member / spouse / parent
☐ An attorney or legal representative
☐ Another entity / business
☐ Other: _____

If no request, but disclosure due to a law compelling the disclosure (e.g. COIDA/RAF or COVID regs, etc.), **please tick here:** ☐

Reason why information is being requested: (please describe fully):

_____

_____

_____

_____

_____

_____

_____

The requesting entity or person was required to complete a PAIA Requester Form (please attach). The outcomes of the request were: _____

_____

_____

_____

_____

_____

_____

_____

COMPLETED BY: _____
(staff / employee / contractor name and surname)

Signature of person completing this form: _____

Date: _____