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 raises 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) (template available from EKA*):

☐ 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 ☐ An attorney or legal representative

☐ A medical scheme / administrator ☐ Another entity / business

☐ A family member / spouse / parent ☐ Other:

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: