PROF CHRYSIS SOFIANOS
PLASTIC & RECONSTRUCTIVE SURGEON

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CONSENT TO PROCESS PERSONAL INFORMATION IN ACCORDANCE WITH THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013 ("POPI")

1. The practice collects, stores, uses, handles, processes, transfers, retains, archives, and otherwise, manages Personal Information.
2. To discharge this duty, the Responsible Party requires my express and informed permission to collect and process my Personal Information or that of my minor dependent/s and adult dependents who are unable to provide their own consent.
3. I hereby give my consent that the practice of Prof. Chrysis Sofianos may collect, process and distribute my personal information where legally required to do so.
4. I understand my right to privacy and the right to have my personal information processed in accordance with the conditions for lawful processing of personal information.
5. I acknowledge that I understand the purpose for which my personal information is required, and for which it will be used.
6. I hereby consent that I understand that third parties will have access to my personal information, and I hereby consent to the practice of Prof. Chrysis Sofianos sharing my personal information strictly for reporting to third parties, including but not limited to other medical professionals, laboratories, medical aids, and insurance companies.
7. The practice of Prof. Chrysis Sofianos is monitored by CCTV for the purpose of crime prevention, except for consultation rooms and bathrooms, to which I provide my consent.
8. I further understand that all my personal information provided to the practice of Prof. Chrysis Sofianos will be held and/or stored securely for the purpose for which it was collected.
9. I declare that all of my personal information provided is accurate and up-to-date.
10. I agree that I will not hold the practice responsible for any loss (direct or indirect) that may arise from the use of my Personal Information.
11. I agree that I may not hold the practice responsible for any loss that may result from the incorrect use or disclosure of information by any healthcare provider to whom the practice has provided Personal Information.
12. I confirm that I have permission of my dependant(s) to give their consent, where such consent has been provided, and I indemnify the practice against this.
13. Transfer outside South Africa: I agree to the practice transferring any Personal Information outside of the borders of South Africa as required.
14. Access: I have the right at any time to request details of any of my Personal Information that the practice holds; such a request shall be made in writing to the Information Officer of the practice.
15. Withholding Consent: I understand that I can withhold consent to the practice of collecting and processing my Personal Information. I agree, in this case, that the practice will not be able to provide services to me.
16. You further hereby consent that the Practice may contact you by any one of the following communication methods/platforms/systems ("communications"); namely: phone, SMS, Email, social media platforms such as WhatsApp, Telegram, Signal or similar services or any future communications. You understand that this communication will be used only for professional communication. You acknowledge that none of these communications are completely secure or encrypted, and you will not hold the Practice responsible for any breach of confidentiality via these communications.

Signature:		Date:	
Full name and surname:			