CONSENT FORM

AUTHORISATION FOR BP MEDICAL AID SOCIETY AND THE ADMINISTRATOR TO DISCLOSE INFORMATION

Please complete this form should you wish to give consent for your medical society information to be disclosed. Submit the completed and signed form via email to **bpmembership@mhg.co.za**.

PLEASE COMPLETE THIS FORM IN BLOCK LETTERS.

MEMBERSHIP DETAILS

Membership number			
Title		Initials	
Surname			
First name			
Identity/Passport number			
Contact number (home)		(work)	
Cell phone number			
Email address			

DETAILS OF THE APPOINTED PARTY

My information may be disclosed to the appointed party specified below:

Identity/Passport number			
Title		Initials	
Surname			
First name			
Contact number (home)		(work)	
Cell phone number			
Postal address			
		Postal code	
Email address			
Relationship			

The above party is the appointed curator/power of attorney

- ☐ Yes
- ☐ No
- ☐ Not applicable

WHAT INFORMATION MAY BE DISCLOSED?

By ticking the relevant box below, please indicate what information may be disclosed to the party/parties referred to on page 1. Please note that any information relating to the categories below will be disclosed.

- ☐ Benefits
- ☐ Claims
- ☐ Contributions
- ☐ All of the above

The time period for which consent will be valid is: _____ to _____
DD/MM/YYYY DD/MM/YYYY

NOTE: If a time period is not specified, the consent will be effective from the date of the signature below and will continue indefinitely thereafter, unless expressly withdrawn by you in writing.

CONSENT

I, the undersigned, hereby:

- authorise BP Medical Aid Society and the Administrator to disclose the information to the party/parties, as indicated above;
- agree that neither BP Medical Aid Society nor the Administrator shall be liable for any loss or damage whatsoever, including direct, indirect and consequential damage, that may arise from the disclosure of any information pursuant to this consent;
- agree that once consent is provided, all information selected may be provided to the party/parties; and
- acknowledge that this consent will continue in force until expressly withdrawn by me.

Name _____

Signature _____ Date _____
DD/MM/YYYY

04/2022