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**APPROVAL FOR ACCESS, USE AND PROCESSING OF PRIVATE INFORMATION:**

I the undersigned \_\_\_\_\_  
FULL NAMES AND SURNAME

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ID/PASSPORT NUMBER

Give hereby my consent that my personal information can be shared with referring clinicians and debt collectors of the practice accounts .

Dated at \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_

Signature \_\_\_\_\_

**TOESTEMMING VIR TOEGANG EN GEBRUIK/VERWERKING VAN PRIVAATINLIGTING:**

Ek die ondergetekende \_\_\_\_\_  
VOLLE NAME EN VAN

\_\_\_\_\_  
ID NOMMER

Gee hiermee my toestemming dat my persoonlike inligting met verwysende klinici en skuldinvorderaars van die praktykrekening gedeel kan word.

Gedateer te \_\_\_\_\_ op hierdie \_\_\_\_\_ dag van \_\_\_\_\_

Handtekening \_\_\_\_\_