Xen Consent

I, ____(full names and surnames) Hereby declare that my information above is correct.I agree/do not agree(delete what is not applicaple) that my doctor can disclose my health records and any other relevant information to the authorized representatives of OPHTHALMOLOGY MANAGEMENT GROUP (OMG) in order to assist me with the payment of the treatment by my medical aid. I realize that my medical scheme may require specific motivations or information to justify the treatment, and that OMG may be able to help with this. I also realize that the support does not mean that the medical aid will neccesarily pay either in full or in part for the medicine or related treatment.I understand that this process may sometimes take a couple of months.

I understand that this assistance will take place with the full co-operation and support of my doctor. I also understand that I can always ask my doctor for futhur advice,including advice on alternative therapies.I understand that my personal information will only be used for the purposes of addressing medical scheme matters.

I understand that I can at any stage opt out of this agreement, and that,so I wish to do so, I will immediately inform my doctor, who will inform OMG and all support will immediately stop and all information destroyed.

By signing this,I confirm that I have not been forced to agree to the above.I understand what this consent means.

Patient signature __________________________ Date ___________________

Doctor signature ___________________________ Date ____________________