University Health Service

UNIVERSITY OF THE PHILIPPINES
DILIMAN, QUEZON CITY

PhilHealth
Accredited

Data Privacy Consent Form

Pursuant to the provisions of the Data Privacy Act of 2012 and the Data Privacy Notice for Students of UP Diliman, you hereby confirm and acknowledge, by signing your name below, that you and/or next of kin/legal representative freely and voluntarily give consent to the collection and processing of your data, which may include personal information and/or sensitive information such as birth date, address, sex at birth, gender identity, contact information, medical information, medication, medical history and other information necessary for health assessment and management (the "Data") set out in the UP Health Service ("UPHS") forms and/or otherwise provided by you or possessed by the UPHS for one or more purpose, as stated hereinafter.

The UPHS shall use the Data for the purpose of your health assessment, treatment, and/or availment of healthcare services in the facility. In relation to these purposes, the UPHS may disclose your personal and/or sensitive information to people involved in your health management (medical staff, dental staff, nurses, allied healthcare personnel, or other UPHS staff, or to other third parties where required or permitted by law or contract, including regulatory authorities and other agencies of the Government.

Moreover, your personal information and/or sensitive information may also be processed by the UPHS for use in the purpose of the following: research and education, medical training, profiling, historical or scientific purpose, and also to generate statistics relevant to the institution's operations and financial performance.

The UPHS shall keep the Data throughout the term of engagement between you and the institution, and for as long as necessary, for the intention of maintaining your medical records and to comply with applicable laws, rules and regulations. You hereby understand that you are entitled to certain rights, in relation to the Data collected from you and/or your next of kin/legal representative, including the right to object to the processing of the Data, the right to access it, the right to rectify any inaccuracies in the Data, and the right to erasure or blocking of the Data. You may consult with our Data Privacy Officer (DPO) for any concerns regarding the Data. Your consent shall remain valid and in force and effect until you revoke the same in writing, and which revocation is duly addressed and received by the UPHS DPO.

Conforme:

_____ _____

Printed Name of Patient/Legal Representative and Signature — Date

_____ _____

Witness — Date