

HOSPITAL CONSENT FORM

Processing of Personal & Health Data — DPDP Act, 2023

DPDPA Legal | Roots Cyber Law Firm | Template Form 07

DISCLAIMER: This form template is prepared by DPDPA Legal, managed by Roots Cyber Law Firm, for compliance guidance under the Digital Personal Data Protection Act, 2023. It does not constitute legal advice. Consult qualified legal counsel before deployment.

1. HOSPITAL DETAILS (Data Fiduciary)

Hospital Name	_____
Address	_____
Contact Number	_____
Email	_____
Grievance Officer (Section 13)	_____
Contact Details	_____

2. PATIENT DETAILS

Full Name	_____
Date of Birth / Age	_____
Gender	_____
Contact Number	_____
Address	_____
Patient ID (if applicable)	_____

3. PURPOSE-SPECIFIC CONSENT (Tick Applicable Boxes)

<input type="checkbox"/>	Creation and maintenance of medical record for diagnosis and treatment
<input type="checkbox"/>	Processing of health information and medical history (Sensitive Personal Data — Explicit consent)
<input type="checkbox"/>	Diagnostic tests and laboratory processing of samples
<input type="checkbox"/>	Sharing medical data internally with authorised doctors and clinical staff
<input type="checkbox"/>	Sharing necessary data with insurance providers / TPAs for billing and claim processing
<input type="checkbox"/>	Processing where required under applicable healthcare laws and regulations
<input type="checkbox"/>	Storage of data in secure Electronic Medical Record systems (EMR)
<input type="checkbox"/>	Telemedicine / digital healthcare processing (if applicable)
<input type="checkbox"/>	Cross-border data transfer where necessary and safeguarded

4. OPTIONAL CONSENT

- I consent to receive health awareness and promotional communication.
- I do **NOT** consent to receive marketing communication.
- I consent to use of my anonymised data for research and academic purposes.
- I do **NOT** consent to research usage.

5. EMERGENCY PROCESSING CLAUSE

■ I understand that in medical emergencies, my personal data may be processed without prior consent where necessary to protect life and health, in accordance with Section 7 of the DPDP Act.

6. PATIENT RIGHTS ACKNOWLEDGMENT

- I understand my rights under DPDPA — access, correction, erasure (subject to legal retention), and grievance redressal.
- I understand I may withdraw consent where legally permissible.

7. WITHDRAWAL OF CONSENT

Email	_____
Hospital Helpdesk	_____
Grievance Officer	_____

8. DATA RETENTION

- I understand that my medical records will be retained in accordance with applicable healthcare regulations and legal requirements.

9. SIGNATURE / DIGITAL ACCEPTANCE

Patient Name:	_____
Signature:	_____
Date:	_____

If patient is a minor — Parent / Guardian Signature: _____ Date: _____

