CASTLE STREET SURGERY

CONSENT TO TRANSFER MEDICAL RECORDS

Dear Doctor,

RE: Request to transfer Medical Records

The below named patient(s) have decided to register with our practice. We would be grateful if you would send us a copy of the medical records for the below named patient(s) at your earliest convenience. Please find written patient consent below in accordance with the requirements of the Data Protection Acts 1988 – 2003.

Yours sincerely,

Dr. Martina Hanratty (M.C.R.N 5106)

Dr. Cyril Crosbie (M.C.R.N 3763)

PATIENT CONSENT

DATE: _____ / _____ / _____ (DAY / MONTH / YEAR)

I _____ (PRINT NAME)
consent to the release of my medical records to
Castle Street Surgery, Castle Street, Roscommon Town.

Date of Birth: _____ / _____ / _____ (DAY / MONTH / YEAR)

_____ (PLEASE SIGN)

ADDITIONAL PATIENTS
(over 18's please sign)

Name: _____
DOB: _____ / _____ / _____
Sign: _____

Name: _____
DOB: _____ / _____ / _____
Sign: _____

Name: _____
DOB: _____ / _____ / _____
Sign: _____

Name: _____
DOB: _____ / _____ / _____
Sign: _____