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CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

Your name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Dear Dr. .... (Please insert your GP name and address here)

The above named patient(s) would like to transfer to Grange Road Family Practice. We would be grateful if you could forward a copy of their medical records to the above address:

1. A summary of all medical notes.
2. Correspondence from hospitals/ clinics.
3. Results of tests.

They have given their written consent below in accordance with the Data Protection Act. Please forward to [grangeroadfamilypractice.gp@healthmail.ie](mailto:grangeroadfamilypractice.gp@healthmail.ie) if you have a practice Healthmail account.

\_\_\_\_\_

Patients Signature: .....

Date:

*Note: All patients aged 16 and over must individually consent and sign.*