CONSENT TO TRANSFER MEDICAL RECORDS

Dear Doctor,

RE: Request to transfer Medical Records

We would be grateful if you could transfer the records of the below named patient(s) to us at your convenience. Please find written patient consent below.

Yours Sincerely,

____

Dr. Mary Behan (M.C.R. 20149)

PATIENT CONSENT

Date: _____ /_____ /_______ (DAY / MONTH / YEAR)

I __________________________________ (PRINT NAME)
consent to the release of my medical records to
Calderwood Family Clinic, 28 Sion Hill Road, Drumcondra, Dublin 9.

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

__________________________________ (PLEASE SIGN)
Patient Signature

ADDITIONAL PATIENTS
(over 18's please sign)

Name: ___________________
DOB: _____ /_____ /______
Sign:

Name: ___________________
DOB: _____ /_____ /______
Sign:

Name: ___________________
DOB: _____ /_____ /______
Sign:

Name: ___________________
DOB: _____ /_____ /______
Sign:

Calderwood
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Calderwood Family Clinic is a registered business name for Dr. Mary Behan, Registered in Dublin No. 448564.