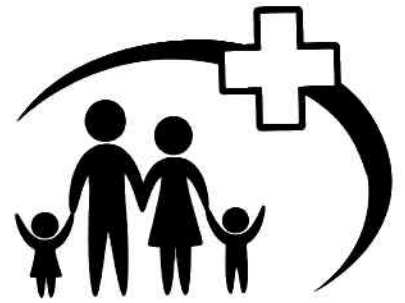


The Medical Centre

Whitehall, Galway, H91 D9FW

Telephone: (091) 564241 Fax: (091) 566020

Email: whitehallmedicalcentre.gp@healthmail.ie



REQUEST FOR MEDICAL RECORDS FORM

You are welcome to Whitehall Medical Centre.

Please supply the following information so that we may retrieve your medical records from your previous GP. Please note, each individual adult must complete their own signed consent form.

All information is treated in the strictest of confidence.

Please complete using block capital letters:

To Dr _____

Date: / /

Address: _____

Patients Name(s): _____

Date of Birth / /

Date of Birth / /

Date of Birth / /

Date of Birth / /

Address:

The above named patient(s) has requested their medical records to be transferred to this practice. I would be grateful if you could forward any medical records or copies of same to the above address.

Below is the patient(s) consent:

Yours Sincerely

Administration

Whitehall Medical Centre

I consent to my/my children's medical records being forwarded to Whitehall Medical Centre.

Signed: _____

Date / /