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:

Date: / /

To Dr______________________________

Address: ______________________________

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Patients Name(s): ____________________ Date of Birth / /

____________________ Date of Birth / /

____________________ Date of Birth / /

____________________ Date of Birth / /

Address: ______________________________

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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

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Administration

Whitehall Medical Centre

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

Signed: ____________________ Date / /