



Request for Information Consent Form

PRIVATE & CONFIDENTIAL

Patient Details

Name: _____

Address: _____

Eircode: _____

Date of Birth: _____

Phone/Email: _____

Date of Request: _____

Information Requested

Transfer of medical file to another GP ☐

GDPR Subject Access Request ☐

GDPR Subject Access Request for my Child ☐

Freedom of Information Request ☐

Copy of my medical file for my own use ☐

Date range of information requested or any specific information required (if any)

Authorisation for Release of Patient Information

I, _____ hereby

request that my records are released to:

Name of Person/Organisation:

Address: _____

Email/Phone: _____

Relationship to Patient: _____

Preferred Method of Transfer:

Secure Email / Collection in Person / Other (Please specify)

I consent to the release of my medical records as indicated above ☐

I enclose a copy of my passport/Drivers License as proof of identity (Required) ☐

Requests relating to Minors must be accompanied by proof of legal guardianship ☐

Signed: _____

Date: _____

Understanding My Rights as a Patient

1. I understand the release of the records will no longer preserve the confidentiality of my records and the information contained therein.
2. Once this health information is disclosed, how the recipient further discloses may no longer be protected under data protection legislation or by Centric Health.
3. I understand that my information constitutes special category data, and I am giving explicit consent for its release
4. Subject Access Requests and Freedom of Information requests will be provided to the patient within 30 days in line with Article 15 GDPR.

Proof of Patient Authentication

Practice Use Only

Identification Verified: Yes / No

ID type: _____

Legal Guardianship Confirmed: Yes / No

Request Processed By: _____

Date Processed: ____ / ____ / ____

Information Released: _____

Method of Release: _____

Notes: _____
