



Consent to Transfer Medical Records

This form authorises the transfer of my medical records from my current GP to a new GP practice, in accordance with applicable data protection and healthcare laws.

Patient Details Full Name: _____

Date of Birth: _____

Address: _____

Eircode _____

Current GP / Practice (Records to be transferred from)

GP / Practice Name: _____

Address: _____

Phone: _____ Email: _____

New GP / Practice (Records to be transferred to)

GP / Practice Name: Terenure Medical

Address: 84A Terenure Road East, Terenure, Dublin6

Phone: 4907077

Healthmail: terenuremedical.gp@healthmail.ie

Consent

I confirm that I am the patient named above, or a person legally authorised to act on the patient's behalf. I consent to the transfer of my medical records, including relevant clinical and administrative information, from the GP practice named above to the new GP practice named above for the purpose of continuing my medical care.

I understand that this information will be transferred securely and used only for the purposes of my ongoing healthcare. I understand that I may withdraw this consent at any time prior to the transfer by contacting my current GP practice.

Patient / Authorised Representative Signature: _____

Print Name: _____

Date: _____