HAZELHILL
FAMILY PRACTICE

TRANSFER OF MEDICAL RECORDS REQUEST

Patient's Full Legal Name:_____

Date of Birth:_____

Address:_____

Dear Doctor,

The above patient(s) has/ have requested transfer of their medical records to this practice. We would be grateful if this could be arranged at your earliest convenience to facilitate their ongoing care.

Practice Healthmail address: hazelhillfamilypractice@healthmail.ie

Signed consent in accordance with data protection regulations has been provided below.

Yours sincerely,

Dr. Caroline Noone.

****

Patient authorisation:

I authorise transfer of my medical records to Hazelhill Family Practice.

_____ _____

Patient Signature **Date**