GREYSTONES HARBOUR FAMILY PRACTICE

TRAFALGAR HOUSE TRAFALGAR ROAD GREYSTONES A63 AY71
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To (Previous GP) **Dr** ______________________________

Address ______________________________

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Your name ____________________ **DOB:** ________ **Address** ____________________

Any other family members (under 18 years) also requesting to be transferred.

Re: ____________________ **DOB:** ______________________

Re: ____________________ **DOB:** ______________________

Re: ____________________ **DOB:** ______________________

The above has decided to register with this practice. I would be grateful if you could send me a copy of their medical records. If you could forward these records at your earliest convenience via **Healthmail** to **ghfp.gp@healthmail.ie** Signed patient consent in accordance with Data Protection Regulations has been provided below.

Dr____________________

PATIENT SECTION

I ____________________ (PRINT NAME)
Consent to the release of my medical records to Greystones Harbour Family Practice.

Signed ________________ Date________________