Good People Medical Centre,
Unit 5 , Southgate Shopping Centre,
A92V08A
041 2134182
Info@goodpeoplemedical.ie

REQUEST FOR MEDICAL RECORDS

Full Name_____

Address_____

_____

DOB_____Mobile_____

I hereby give my consent for my medical records to be transferred to Good People Medical Centre

From Dr _____

Address_____

Signed_____Date_____

Family members (under 18 can be listed below and signed by Parent/ Guardian)

Name _____DOB_____Sign_____

Name_____DOB_____Sign_____

Name_____DOB_____Sign_____

Name_____DOB_____Sign_____