KELLS
MEDICAL

046 940 4004
info@kellsmedical.ie
www.kellsmedical.ie
Church Street, Kells, Co.Meath

Medical Record Request Form

To Doctor: .....

.....

.....

The following patient/s has registered at the practice and consented to have a copy of their files forwarded to this surgery

I would be grateful if you would send the medical records to kells.gp@healthmail.ie at your earliest convnenience.

Name: ..... Date of Birth:...../...../.....

Address:..... Medical Card No:.....

..... Male/Female

..... Telephone No: .....

Additional Family Members:

..... Date of birth:...../...../..... Male/Female

..... Date of birth:...../...../..... Male/Female

..... Date of birth:...../...../..... Male/Female

..... Date of birth:...../...../..... Male/Female

I give consent for my medical files to be sent to Kells Medical.

_____ ...../...../.....
Patient Signature: Date:

_____ ...../...../.....
Gp Signature Date

Surgery Stamp :