Ballincollig Primary Care Centre,
Old Fort Road,
Ballincollig,
Cork
P31 XN96

www.eastgatemedical.ie
(021) 4870808

EASTGATE
MEDICAL

CHANGE OF DOCTOR AUTHORISATION FORM

Name: _____

Address: _____

_____

_____

Date of Birth: _____

Additional family members (wishing to join the practice):

Name: _____ D.O.B.: _____

Name: _____ D.O.B.: _____

Name: _____ D.O.B.: _____

Name _____ D.O.B.: _____

Name: _____ D.O.B.: _____

I consent to the release of my medical notes to Eastgate Medical.

Signed: _____ Date: _____

Dear Doctor _____

The above named has recently joined our practice. We would appreciate if you would please forward their medical records. Many thanks in advance.

Kind regards,

Eastgate Medical

Please forward records to: sheena.finn@healthmail.ie