INCHICORE
Medical Centre

15 Grattan Crescent,
Inchicore, Dublin 8,
D08 EWF2

E: info@inchicoremedical.ie
W: www.inchicoremedical.ie
T: 01 473 4030

Release of Medical Records Form

Complete this form if you wish for your previous GP to send your records to us.

Name _____

Address _____

_____

DOB _____

Please list names of dependents under the age of 16:

Name	**DOB**
_____	_____
_____	_____
_____	_____
_____	_____

Details of previous GP:

Name: _____

Address: _____

_____

Please send my/our medical records to Inchicore Medical Centre.

X Signed: _____ Date: ____/_____/_____

Dear Doctor,

The above named has registered with this practice. Please send a copy or summary of his / her medical records. **Records can be sent to inchicoremedical.gp@healthmail.ie**

Thank you.

_____
on behalf of Inchicore Medical Centre
15 Grattan Crescent, Inchicore, Dublin 8 Tel: 01 4734030