



TRANSFER OF MEDICAL RECORDS CONSENT FORM

I, _____ (Name of Patient)

of, _____ (Address of Patient)

_____ Post Code _____

_____ (Date of Birth)

hereby authorise, _____ (Name of Previous GP and
Practice)

_____ to release my patient held record / summary and forward it to

_____ (Name of GP and Practice)

_____ (Postal Address)

_____ (MMEEx Address)

_____ Patient Signature

_____/_____/_____ Date

OFFICE USE ONLY

Copy Sent: ____/____/_____

Signature of Practice Representative: _____

Note Entered in Practice Software

Notes: _____