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The Surgery, Athenry Primary Care Centre

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Change of Information Form

Download and use this form to notify us of any changes to your personal information
Complete using block capital letters

Surname: ______________________ **First Name**: ___________________

Date of Birth: / /
(For verification purposes)

(Only complete the information which should be changed on your patient file)
Address:____

____

Postal/Eircode: _____________

Tel No: ____________________________ **Mobile:** _______________________

Email Address: ____________________________________

Medical Insurance Company: ______________ **Policy Number:** __________

Medical Card number: ________________ **Exp Date:** ______________

Next of Kin full name: ________________________________

Next of Kin D.O.B: _____________

Relationship: ________________

Next of Kin mobile number: _____________________________

We use text and email to give you confirmation of appointments and some test results. Please indicate whether you would like to give your consent for us to send you information using both these methods:

Yes ☐ No: ☐ (please tick one)

DATA PROTECTION AND FREEDOM OF INFORMATION NOTICE

The Surgery will treat all personal information and data you provide as part of this application, as confidential and store it securely. When The Surgery receives the completed amendment form, it will amend the computer record for the named applicant. This record will contain the relevant personal information you have supplied. This personal record will be used and kept by The Surgery, for the purposes of delivering healthcare services to you. The Surgery will not disclose (share) to other people or organisations the personal information you have given unless consent has been given by the person authorised to give this consent, or if The Surgery is required to do so by law.

Signature: ____ Date: ____/_____/_____ (Please note this is optional.)