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**The Surgery, Athenry Primary Care Centre**

Raheen, Athenry, Co.Galway H65 KH93

### Request for Medical Records Form

*You are welcome to The Surgery Athenry.*

*Please supply the following information so that we may retrieve your medical records from your previous GP for you and if applicable your dependents. Please note, each individual adult must present their own signed consent form.*

*All information is treated in the strictest of confidence.*

*Please complete using block capital letters*

To: Dr \_\_\_\_\_

Date: / /

Address: \_\_\_\_\_  
\_\_\_\_\_

Patients Name(s): \_\_\_\_\_

Date of Birth: / /

\_\_\_\_\_

Date of Birth: / /

\_\_\_\_\_

Date of Birth: / /

\_\_\_\_\_

Date of Birth: / /

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The above named patient(s) has requested their medical care to be transferred to this practice. I would be grateful if you could forward any medical records or copies of same to the above address.

Below is the patient(s) consent.

Yours Sincerely,

\_\_\_\_\_  
Administration  
The Surgery, Athenry

I consent to my/my childrens medical records being forwarded to the above address.

Signed: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_