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Transfer of Medical Records

Patient Name: _____

Date of Birth: _____

Address: _____

I, _____, authorise Dr. _____ of Rialto Medical,
to request my medical records be sent to Rialto Medical from the doctor outlined below.

Previous G.P. _____

Address: _____

Signature: _____

Date: _____

Please return records via Healthmail to: rialtomedical.gp@healthmail.ie or by post to the above address.