Prospect Health Centre

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This is to confirm that this patient is now registered with this practice. Please find consent for release of medical records listed below.

I, ____ give consent for my

medical records to be sent to this practice.

My date of birth: ______________________

My address when I was registered with your practice:

……………………………………………………….

……………………………………………………….

……………………………………………………….

……………………………………………………….

Signed: ______________________________

Date: ________________________________

Other Family Members medical records requested:

Name:	DOB:
______________________________	____________
______________________________	____________
______________________________	____________
______________________________	____________