Consent Form for Transfer of Medical Records

Bray Women's Health Centre
Bri Chualann Court, Adelaide Rd, Bray, Co. Wicklow
Under Dr. Gillian McCutcheon

Patient Information

Full Name: _____

Date of Birth: _____

Address: _____

Telephone Number: _____

Email Address: _____

Consent for Transfer of Medical Records

I, _____ (Patient Name), hereby give my consent for Bray Women's Health Centre to transfer my medical records to Rose Clinic Bray. This transfer is to ensure continuity of my care under the specialists in Menopause and Women's Health, Dr. Aoife Nic Shamhráin and Dr. Ciara McKenna.

New Clinic Details:

- **Clinic Name:** Rose Clinic Bray
- **Specialists:** Dr. Aoife Nic Shamhráin and Dr. Ciara McKenna
- **Website:** RoseClinicBray.ie
- **Email:** info@roseclinicbray.ie
- **Number:** (01) 276 1522

I understand that my medical records will include all relevant information required to continue my care effectively, including but not limited to, medical history, treatment plans, and any other pertinent details.

By signing this form, you authorise the transfer of your medical records as specified above. This consent will remain in effect until the transfer is complete or until you provide written notice to revoke it.

Thank you for your cooperation.

Patient's Signature: _____ **Date:** _____

Contact Information for Transfer Queries:

Rose Clinic Bray
Specialists in Menopause & Women's Health

- **Rose Clinic Bray:** info@roseclinicbray.ie
- **Bray Women's Health Clinic:** health@braywomenshealthcentre.ie

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For Office Use Only:

Received By: _____ ***Date:*** _____

Transferred By: _____ ***Date:*** _____