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REQUEST FOR MEDICAL RECORDS AND CONSENT

Please complete and sign this form and e-mail to medicalrecords@markfeneley.com with proof of ID (copy of drivers licence or passport)

Patient Name	
Date of Birth	
Home Address	
E-mail Address	
Telephone Number	
Proof of ID	

I AM REQUESTING A COPY OF MY MEDICAL RECORDS FROM MR MARK FENELEY'S FORMER PRACTICE AND CONSENT TO THEM BEING SENT TO THE EMAIL ADDRESS GIVEN ABOVE.

I understand that the Medical Record will be sent encrypted through Egress Switch or Password Protected Zip-7 Zip File.

Name:

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Signed:

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Date:

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My preference is:

Egress Switch Encrypted ____________

Zip-7 Password Protected ____________