WESTMED FAMILY PRACTICE

Dr Sadaf Amir MBBS, MICGP, DRCOG (UK), DCH(RCPI)

Unit 1A, Tyrrelstown Plaza, Dublin 15, D15 K667.

Tel: 01 9125670

Patient Consent Form for Transfer of Medical Records

Patient Information:

Full Name: _____ Date of Birth: _____ Address:

_____

Phone Number: _____ Email: _____

Receiving Clinic Information: **Westmed Family Practice**

Address**: Unit 1 Block A, Tyrrelstown Plaza, Dublin D15K667**

Email: **sadaf.amir@healthmail.ie**

Consent:

I, hereby authorize _____ to release my complete medical records, including but not limited to, medical history, treatment records, laboratory results, imaging reports, and other pertinent information, to Westmed Family Practice

Purpose of Transfer: 1.Continuation of Care (Please check the applicable reason)

2.Second Opinion 3.Change of Healthcare Provider 4. Other (please specify):

_____

Patient Signature: _____ Date: _____

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Text Message Consent Form

Patient Name: _____ Date of Birth: _____

Address: _____

_____ Phone: _____

1. I Consent to the practice contacting me by text message for the purpose of receiving appointment reminders and notifications that test results are available. 2. I acknowledge that appointment reminders by text are an additional service, that they may not take place on all occasions and that the responsibility of attending or cancelling appointments still rest with me. I understand if I am not able to keep an appointment, I must phone the surgery to cancel.
3. Text messages are generated using secure facility but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure.
4. The surgery does not offer a reply facility to enable patients to respond to text messages directly.
5. I agree to advise the practice if my mobile number changes or is no longer in my possession.

Patient Signature: _____.

PRINTED Patient name: _____.

Date: _____.

Please inform staff at reception if your number has changed or if you wish to withdraw from the text messaging service by calling: 01-9125670

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In order to provide you with care we need to collect and keep information about you and your health in your personal medical record. Please complete all parts of the form. The information will be used to create your personal medical record on the practice computer. Our practice is consistent with the Medical Council guidelines and the privacy principals of the Data Protection Acts.

Patient Registration Form

Personal Details	
First Name:	**Surname:**
Title: Mr, Mrs, Ms, Other:	**Gender: Date Of Birth:**
Address:	
Mobile Number:	**Home Number:**
Email: **I would like to receive alerts from the practice by: Mobile Phone□ Email:□**	
PPS Number:	**Medical card/Dr Visit Card Number:**
Next Of Kin Name:	**Contact Number:**
Address: If different from yours:	
Relationship to patient:	
Previous GP Name & Address:	
Pharmacy Name & Address:	
The following information is not essential but may be of use to your doctor for diagnosing or treating a problem.	**Occupation:** **Country of Birth:**
Health Details	
Allergies:	
Medical History:	

Surgical History:
Current Medications:

I confirm that I have been offered sight of the Practice Privacy statement, GDPE data processing statement and consent to electronic communications statement.

Signed: _____ Date: _____

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PATIENT CONSENT FOR PROCESSING OF HEALTH DATA

To assist with your care, we at Westmed Family Practice we need to collect personal data about you. This information will include details of your health and your treatments. We may also need to record additional information that while may not seem to relate directly to your health it would help in our treatment of you. Examples of this kind of information would include things like your age, gender, material status, number of children you have, your nationality and your employment details.

PATIENT DECLARATION

- I understand my health information will be seen or shared only with medical and administrative staff involved in my care or where Westmed Family Practice is required to do so by law.
- I understand that for the purpose of my treatment administrative staff may have to access my health data. Reasons for this access would include the opening of letters and recording of information from hospitals about me, downloading and saving in my file results from laboratories, typing of letters to hospitals and other similar health related issues.
- I understand that all of Westmed Family Practice staff sign a confidentiality agreement that binds them not to disclose my details to any unauthorised persons not involved in my care. • I understand that any health data shared outside of the practice is for the purpose of my health treatment will normally be limited to the information related to a particular treatment and not my entire file.
- I understand that my health data will be stored primarily on a secure database operated by a specialist company called Clanwell Health and I understand that Clanwell Health are only allowed process my health data under Westmed Family Practice instructions.
- I understand that the law provides that in certain instances personal health information can be disclosed e.g. in the case of some infectious diseases.
- I understand that Westmed Family Practice will only release information to, for instance solicitors or insurance companies at my request.
- I understand that I can withdraw consent for processing of my personal health data at any time.

I _____ Date of birth: _____ thereby freely consent for Westmed Family Practice to process my personal data, including health information, for the purpose of my on-going health care treatment in accordance with what I understand above.

Patient Signature: _____ Today's Date: _____