**Deansgrange Medical Centre**

**CONSENT FOR**

**COLLECTION OR EMAIL OF DOCUMENTS BY/TO A THIRD PARTY**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Patient name]

consent to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[nominated persons name]

and / or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[second nominated persons name

Collecting documents from Deansgrange Medical Centre on my behalf, and/or I consent to documents being sent to the email of my choice which is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I know that I can withdraw my consent to this at any time, by contacting Deansgrange Medical Centre.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return this signed form by post or email to [info@deansgrangemedical.ie](mailto:info@deansgrangemedical.ie)