Bowel Diagnostics & Therapy

Transfer of Medical Records Consent Form

BOWEL DIAGNOSTICS & THERAPY

Patient Name _____ Date of Birth / /

Signature _____ Date / /

I hereby grant my consent for all medical records relating to me (and/or my child) to kindly be forwarded

FROM _____
(Practice holding your records)

TO **Bowel Diagnostics & Therapy**

via post or Medical Objects. Thank you!

Additional Family Members
(You may sign for your child/patient under your legal guardianship if they are minor/s.)

Patient Name _____ Date of Birth / /

Signature _____

Patient Name _____ Date of Birth / /

Signature _____

Patient Name _____ Date of Birth / /

Signature _____

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