Patient Data Consent Form

An Roinn Gnóthaí Fostaíochta
agus Coimirce Sóisialaí
Department of Employment Affairs
and Social Protection

Department of Employment Affairs and Social Protection –

Data consent form

Name: _____

PPSN: _____

DOB: _____

I the undersigned, authorise _____ Medical practice to transfer my personal data for the purposes of claiming and proving eligibility to Illness/Disability Schemes to the Department of Employment Affairs and Social Protection. My consent remains valid for all future transactions with the Department, unless I revoke it in writing.

I understand that I may revoke this consent at any time by contacting the Department or by informing the medical practice in writing.

Signature of patient: _____

Signature on behalf of medical practice: _____

Date: _____

PLEASE Return To Cara Medical