Student Health Service
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OLLSCOIL TEICNEOLAÍOCHTA BHAILE ÁTHA CLIATH
TECHNOLOGICAL UNIVERSITY DUBLIN

CONSENT TO RELEASE OF MEDICAL RECORDS

I, the undersigned, do hereby consent to the release of my medical records

Name: _____

Date of Birth: _____

Address: _____

_____

Student Number: _____

Course Code: _____

Tel number: _____

I consent to the release of my medical records to:

_____

_____

_____

_____ _____

Signature of Student **Date**