



BALLINA MEDICAL CENTRE,
KEVIN BARRY STREET,
BALLINA, CO. MAYO.
F26 P6P1

TEL: 096 80600
EMAIL: INFO@BALLINAMEDICALCENTRE.IE
WEB: WWW.BALLINAMEDICALCENTRE.COM

DR SEAN MOFFATT
DR MICHEAL MOFFATT
DR AUDREY ROUSE
DR MAURA IRWIN

BALLINA MEDICAL CENTRE – EXCELLENCE IN COMMUNITY MEDICINE

Change of Information Form

Download and use this form to notify us of any changes to your personal information

Complete using block capital letters

Surname: _____ **First Name:** _____

Date of Birth: / /
(For verification purposes)

(Only complete the information which should be changed on your patient file)

Address: _____

Postal/Eircode: _____

Tel No: _____ **Mobile:** _____

Email Address: _____

Medical Insurance Company: _____ **Policy Number:** _____

Medical Card number: _____ **Exp Date:** _____

Next of Kin full name: _____

Next of Kin D.O.B: _____

Relationship: _____

Next of Kin mobile number: _____

We use text and email to give you confirmation of appointments and some test results. Please indicate whether you would like to give your consent for us to send you information using both these methods:

Yes No: (please tick one)

DATA PROTECTION AND FREEDOM OF INFORMATION NOTICE

The Surgery will treat all personal information and data you provide as part of this application, as confidential and store it securely. When The Surgery receives the completed amendment form, it will amend the computer record for the named applicant. This record will contain the relevant personal information you have supplied. This personal record will be used and kept by The Surgery, for the purposes of delivering healthcare services to you. The Surgery will not disclose (share) to other people or organisations the personal information you have given unless consent has been given by the person authorised to give this consent, or if The Surgery is required to do so by law.

Signature: _____

Date: ____/____/____ (Please note this is optional.)