

Dear Doctor	Phone
Email	
Address	
The following na	amed patients has asked me to be involved in their medical care.
I would apprecia	ate if you could release their medical records.
Patient Name	Date of Birth
	Date of Birth
Address	
Signed	
Patient Name	Date of Birth
Address	
Ciam and	
Signed	
Patient Name	Date of Birth
Address	
Signed	
_	
Doctor Signatur	e Date

Dr. Fiona Kelly

MICGP, MB, BCh, BAO, BMedSc, MMedSc, DCH, DCP, DOWH, Diploma in Therapeutics, Certificate in Geriatric Medicine, Certificate in Family Planning, Certificate in Experience in Long-Acting Contraceptive Devices, Certificate in IUCD Insertion, Level 1 Methadone Treatment