ANYTOWN MEDICAL PRACTICE
Main Street Anytown,
PH: 01-2345678 Fax: 01-9012345

Name of Medical Student:_____

Student ID number: _____

Medical School: _____

Period of Attachment From: _____ To: _____

Name of GP assigned to: _____

I confirm that, while attached to the Anytown Medical Practice, I agree to the following principles of confidentiality:

- Any personal data concerning patients which I have learned by virtue of my position as medical student attached to this practice will be kept confidential both during and after my attachment
- I will only discuss cases seen during the course of my attachment with GPs from the practice or at recognised teaching sessions organised by the medical school. Patient information will be kept anonymous during these discussions. Likewise, if writing about patients for assignments, learning logs etc. I shall retain the patient's anonymity e.g. by using only initials or a pseudonym and excluding any potentially identifying information such as address or date of birth.
- I will not remove any documents or property from the practice without advanced authorisation from the responsible GP
- I will not access medical records belonging to me, members of my family or those known to me without advanced authorisation from the responsible GP

Medical Student:

Name: (Block Capitals) _____

Signature: _____

Date: _____

Responsible GP:

Name: _____

Signature: _____

Date: _____

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<Date>

To: *<GP Name>*

<GP Address>

Re: *<Patient Name>* **DOB:** *<Patient DOB>*

Dear *<GP Name>*

The above has decided to register with this practice. I would be grateful if you could send me a copy of the medical records. Signed consent in accordance with the Data Protection Acts has been provided below.

Yours Sincerely

_____

Dr Joseph Bloggs (M.C.R. 34567)

PATIENT SECTION

<Date>

I _____ (PRINT NAME) consent to the release of my medical records to Dr Black

_____

Patient Signature