

## 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: \_\_\_\_\_