

Consent to Transfer Information

Name of person whose Referral is to be transferred	
Name of Patient (if different)	

- Yes, I consent to information regarding my referral and data held by VoiceAbility being transferred to POhWER by the 1st of April 2017.
- No, I do not consent to information regarding my referral and data held by VoiceAbility being transferred to POhWER and understand my file with VoiceAbility will be closed as a result

Signature:	
Date:	

strengthening voice, championing rights, changing lives

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