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:	