



## REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

In order to receive the best care possible, I agree to Ōtorohanga Medical obtaining my medical records from my previous doctor. I understand that this will remove my name from their practice register.

**Previous Medical**

**Centre:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Ph:** \_\_\_\_\_

*Otorohanga Medical prefer electronic GP2GP notes transfer.*

Each person 16 years or over to complete and sign own form.

Please transfer the medical records for the following people:

Family Name:	Given Names:	DOB:	NHI:

**NB. Parent or Caregiver to sign if you are under 16 years**

<b>Signatory Details</b>	Signature	Date
<b>Authority Details</b> <i>(where signatory is not the enrolling person)</i>	Full Name	Relationship
	Basis of authority (e.g. parent of a child under 16 years of age)	

<b>Office Use Only:</b>	Fax:	Ph:	Date Faxed:
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Doctor	NZMC
Dr Joyce Wong	33003
Dr Josh Coulter	75676
Dr Jo Ann Francisco	64080
Dr Russ Fernandez	65494
Dr Michael Becker	21892
Dr Fraser Hodgson	12629