Practice Name/Address

**REQUEST TO HAVE**

**MEDICAL RECORDS TRANSFERRED**

***Each person 16 years or over is required to complete and sign their own form***

**Previous GP Clinic name:**

**Please transfer the medical records for the following people to {XXX Practice NameXXX} Medical Centre:**

|  |  |  |  |
| --- | --- | --- | --- |
|  **NHI** | **Family Name** | **Given Names**  | **Date of Birth** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

 **Please send electronic GP2GP notes transfer to:**

**EDI – XXXXXXXX**

*{Optional}* **Please tick which Doctor you would like to register with:**

Dr {First Name} {Last Name} – NZMC# XXXXXX **⬜**

Dr {First Name} {Last Name – NZMC# XXXXXX **⬜**

 *In order to receive the best care possible, I agree to* **{XXX Practice NameXXX}** *obtaining my medical records from my previous doctor. I also understand that I will be removed from their practice register.*

***Signed: Date:***