REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

EACH PERSON 16YRS OR OVER TO COMPLETE AND SIGN OWN FORM

In order to receive the best care possible, I agree to Morrinsville Medical Centre obtaining my medical records from my previous doctor. I also understand that I will be removed from their patient register.

Previous Medical Centre:_____________________________________

Address of Medical Centre:___________________________________

Phone:_________________________ Fax:________________________

Please transfer the medical records for the following people to Morrinsville Medical Centre.

Family Name	Given Names	DOB or NHI

Our practice is able to receive and would prefer electronic GP2GP notes transfer.

EDI: morrinmc

Dr Chris Douie	NZMC 32606 o	Dr Anne Murphy	NZMC 09021 o
Dr Thaier Maky	NZMC 33294 o	Dr Gishani Egan	NZMC 32030 o
Dr Naresh Parsotam	NZMC 14107 o	Dr Dorothy Smyth	NZMC 19297 o

Signed: _________________________ Date: ___________________

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