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 Dominique Hite NZMC 59378 o
Dr Dot Smyth NZMC 19297 o
Dr Gillian Brown NZMC 11205 o
Dr Michel Arnephy NZMC 42646 o

Signed: _____ **Date:** _____

Morrinsville Medical Centre
17-19 Canada Street
PO Box 86
Morrinsville 3300

Ph: 07 889 5126
Fax: 07 889 5123
Email: postmaster@mormc.co.nz