

REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

EACH PERSON 16 YEARS OR OVER IS TO COMPLETE AND SIGN THEIR OWN FORM

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

Previous GP: _____

Address: _____

Please transfer the medical records for the following people to:

**Hamilton East Medical Centre
16 Beale Street, Hamilton 3216 • PO Box 4096, Hamilton 3247**

Fax: 07 834 0928 • Ph: 07 839 1232

Healthlink EDI: HAMESTMC

Please send records GP2GP/EDI – ****we do not accept discs or USB****

	GP	NZMC
	Dr Asit Parekh	27214

	GP	NZMC
	Dr Zig Khouri	12515

Family Name	Given Names	DOB or NHI

****If you are over the age of 16 you are required to sign your own form****

Patients current address	
Signed	
Full Name & Relationship (if signing in behalf of child)	
Date	