

# REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

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**EACH PERSON 16 YEARS OR OVER IS TO  
COMPLETE AND SIGN THEIR OWN FORM  
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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			GP	NZMC
					Dr Tama Blaiklock	49861

Family Name	Given Names	DOB or NHI

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

<b>Patients current address</b>	
<b>Signed</b>	
<b>Date</b>	