REQUEST TO HAVE
MEDICAL RECORDS TRANSFERRED

(Each person 16 years or over to complete and sign own form)

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

Previous Medical Centre: _____

Address: _____

Email: _____

Please transfer the medical records for the following people to:

Rata Health
284 Peachgrove Road
Postal Address: PO Box 14121, Hamilton, 3252

First Name: Rata	**Last Name: Health**
MCNZ: 1234	**EDI: fivex**

We prefer electronic GP2GP notes transfer.

Please also **de-register patient from MMH portal** if applicable.

Family Name	Given Names	DOB or NHI

Signed: _____ Date: _____

Rata Health
284 Peachgrove Road, P O Box 14121,
HAMILTON 3252.

Telephone: 078557824
Fax: 078558927
Email: admin@ratahealth.co.nz