

**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: _____

Telephone: _____ **Fax:** _____

Please transfer the medical records for the following people to:

RATA HEALTH
284 Peachgrove Road
Postal Address: PO Box 14121, Hamilton, 3252
Healthlink EDI: fivex

We would prefer electronic GP2GP notes transfer

✓	GP	NZMC
	Dr Jeffrey Chen	38506
	Dr Anisha Dubey	62427
	Dr Hena Mahal	43687

PLEASE ALSO DE-REGISTER PATIENT FROM MMH PATIENT PORTAL IF APPLICABLE

Family Name	Given Names	DOB or NHI

Patient's current address: _____

Signed: _____

Date: _____