Rata Health
family care

National Hauora Coalition

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.

Parent/Guardian:		
Family Name	**Given Names**	**DOB or NHI**
Dependants/Under 16:		
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