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: _____

Telephone: _____

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

Patient's current address: _____

Signed: _____ Date: _____

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

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