



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 Redicare obtaining my medical records from my previous doctor. I also understand that I will be removed from their practice register.

To: _____

Address: _____

Please transfer the medical records for the following people to Redicare

Family Name	Given Names	DOB or NHI

Our practice is able to receive and would prefer electronic GP2GP notes transfer.

Dr Lulu Fu NZMC 65124

Our EDI: redicare

Signed: _____

Date: _____