



# OTOROHANGA MEDICAL

13 Kakamutu Rd, PO Box 7, Otorohanga  
Ph: 07 873 7079 Fax: 07 873 7078  
EDI ADDRESS: otoromco



## REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

In order to receive the best care possible, I agree to Otorohanga Medical obtaining my medical records from my previous doctor. I understand that this will remove my name from their practice register.

Doctor	NZMC
Dr Russ Fernandez	65494
Dr Joyce Wong	33003
Dr Cheryl Ruarau	59325
Dr Michael Becker	21892
Dr Bhanu Sivakumar	62654
Dr Jo Ann Francisco	64080

Otorohanga Medical is able to receive and would prefer electronic GP2GP notes transfer.

**Previous Doctor:**  
**Address:**

Each person 16 years or over to complete and sign own form.  
Please transfer the medical records for the following people:

Family Name:	Given Names:	DOB:	NHI:

**NB. Parent or Caregiver to sign if you are under 16 years**

<b>Signatory Details</b>	Signature		Date
<b>Authority Details</b> <i>(where signatory is not the enrolling person)</i>	Full Name		Relationship
	Basis of authority (e.g. parent of a child under 16 years of age)		
<b>Office Use Only:</b>	Fax:	Ph:	Date Faxed: