mercurybay
medicalcentre
Providing quality Rural health care

Request to have medical records transferred:

(*Each person Aged 16 and over is to sign their own form*)
In order to receive the best care possible, I agree to Mercury Bay Medical Centre obtaining my medical records from my previous doctor. I also understand that I will be removed from their practice register.

✸We prefer GP to GP Transfer✸
✸Please print & fax recall list before transferring file✸

Practice Mailbox: mercbaym
NZMC: 0000 Name: Practice Nurse

Previous Doctor: _____

Address: _____ **Fax No:** _____

Please transfer the medical records for the following people to Mercury Bay Medical Centre

Family Name	Given Names	Date of Birth

Inform your previous practice of your new address:

_____

_____

New Phone: _____ **Signed:** _____ **Date:** _____

Faxed		Tasked	

Pinnacle
Midlands Health Network

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