FEILDING
HEALTH CARE
Hauora Tangata

REQUEST FOR THE TRANSFER OF MEDICAL RECORDS

PREVIOUS DOCTOR'S DETAILS		
Name		
Physical Address	Street number and Name of Street	City/Town
	Suburb	Postcode

The following patients will now be attending Feilding Health Care.
We request that all relevant clinical information be forwarded to us.

Please forward any electronic notes GP2GP to Healthlink mailbox: Feilding
If only available in paper form, please send to our address shown right:

Feilding Health Care
PO Box 8
Feilding 4740

P 06 323 9696
F 06 323 9690
E hello@fhc.nz

PATIENT DETAILS	Doctor's Name and NZMC		
Title	First Name(s)	Family Name	
Physical Address	Street or Rapid (rural) number and Name of Street	City/Town	
	Suburb	Postcode	
Phone		Date of Birth	

OTHER FAMILY MEMBERS UNDER AGE OF 16		
Name		Date of Birth
Name		Date of Birth
Name		Date of Birth
Name		Date of Birth
Name		Date of Birth
Name		Date of Birth

☐ I give permission for my medical records, and those of the above family members to be transferred to Feilding Health Care.

SIGNED _____

Date _____