



RELEASE OF PATIENT MEDICAL RECORDS

I,..... Date of birth.....

would like to collect my medical records for myself / and the following family members

.....Date of Birth.....

.....Date of Birth.....

.....Date of Birth.....

.....Date of Birth.....

.....Date of Birth.....

(All patients 16 years and over must also sign this request)

I / we are moving from the area / overseas and would like to collect the records on.....

The paper records will now become the responsibility of the patient/s named above and only electronic records will be kept by Waiuku Health Centre

Signed

Date