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| Please complete this form and return it to us with proof of identity by **email** to**:** feedback@whakarongorau.nz or by **post** to**:** Privacy Officer, Whakarongorau Aotearoa, PO Box 9980, Newmarket, Auckland 1149. |
| **Service user (patient) details** - person whose records are to be removed or transferred |
| Surname: |  |
| First name(s): |  |
| Email address: |  |
| Date of birth: |  |
| Phone numbers: | Home:  |  | Mobile: |  |
| **Requestor details** |
| Name: |  |
| Relationship to service user: |  |
| Email address: |  |
| Phone number: | Home:  |  | Mobile: |  |
| Signature:  |
| *Proof of identity is required – please attach a copy of your driver licence, passport, or other form of ID* |
| **Authority to make this request** |
|[ ]  I am the service user |
|[ ]  I am the parent/legal guardian of the service user who is under 16 years of age |
|[ ]  I am, or have authorisation from, the executor of the deceased service user’s estate |
|[ ]  I have enduring power of attorney over the service user’s affairs |
| **Archiving of records** |
| Please detail which records you would like archived from our database. If you would like us to provide you with a complete copy of these records before we archive them, please let us know. |
| **Transfer of records** |
| Please detail which records you would like transferred to your healthcare provider: |
| Name and address of your healthcare provider: |

**Request to Archive or Transfer Records**