|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please complete this form and return it to us with proof of identity by **email** to**:** [feedback@whakarongorau.nz](mailto: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**