

DEREGISTRATION FORM



I am registered as a patient at my new GP

General practice: _____

Full name of GP : _____

Street : _____

Postcode: _____ Town : _____ Country : _____

Phone : _____ email : _____

Date of registration with new GP : ____/____/20____

Personal data

Surname : _____

Initials : _____ Date of birth : ____/____/____

BSN nr.: _____ Sex : male female

Transfer of medical data

- I request that you transfer my medical file to my new GP.
- I want to collect and store my medical data myself. (eg. moving abroad)
To identify yourself **bring a valid ID**
- I hereby authorize _____ DOB: _____
to collect my medical file for self storage.
This person should bring their own **valid ID** and a **copy** of your **valid ID**.
- I do **not** want to the transfer my medical data to my new GP or myself.
In this case, the file will be kept at Huisartsenpraktijk de Pelikaan for 20 years.

Date : ____/____/20____

Signature : _____

If multiple persons are deregistered, please do so on the next page

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UITSCHRIJFFORMULIER INWONENDEN

Please deregister at the same time as me:



PARTNER

Surname : _____

Initials : _____ Date of birth : ___/___/_____

BSN nr.: _____ Sex: male female

Transfer of medical data: Yes Collect (valid ID) Authorize (valid ID + copy ID) No

Date: ___/___/_____ Signature : _____

CHILDREN UNDER THE AGE OF 16

Surname : _____

Initials : _____ Date of birth : ___/___/_____

BSN nr.: _____ Sex: Male Female

Surname : _____

Initials : _____ Date of birth : ___/___/_____

BSN nr.: _____ Sex: Male Female

Surname : _____

Initials : _____ Date of birth : ___/___/_____

BSN nr.: _____ Sex: Male Female