Medical File Transfer Consent

Date: ___________________________

To Whom It May Concern,

I, **[Patient's Full Name]**, born on **[Date of Birth]**, hereby authorize **[Current Healthcare Provider's Name]** to transfer my medical records to **[Receiving Healthcare Provider's Name]**.

The records to be transferred include:

- [Lab Results]
- [Imaging Reports]
- [Other Relevant Information]

This consent is valid until [Specify Date] or until I provide written notice to revoke this consent.

By signing below, I acknowledge that I have read and understood this consent form.

Signature: ___________________________

Printed Name: _______________________

Date: _______________________________

Contact Information:

Phone: _____________________________

Email: ______________________________

Thank you for your attention to this matter.