Medical Records Transfer Authorization

Date: [Insert Date]

From:

[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

To:

[Recipient's Name/Office]
[Recipient's Address]
[City, State, Zip Code]

Dear [Recipient's Name],

I, [Your Name], hereby authorize the transfer of my medical records to the above-mentioned recipient. My date of birth is [Your Date of Birth], and I have been a patient at [Your Current Healthcare Provider's Name] since [Start Date of Treatment].

Please send my medical records, including but not limited to [specify records needed, e.g., "consultation notes, lab results, imaging studies"], to the address provided above.

This authorization will expire on [Expiration Date], unless otherwise specified.

Thank you for your attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]
[Your Printed Name]