Authorization for Medical Record Transfer

Date: [Insert Date]

To: [Recipient's Name/Title]

Address: [Recipient's Address]

Dear [Recipient's Name],

I, [Your Name], authorized the transfer of my medical records from [Current Medical Provider's Name] to [New Medical Provider's Name]. This authorization is valid from [Start Date] to [End Date].

Please send all relevant medical records including but not limited to:

- Medical history
- Test results
- Treatment records
- Immunization records

If you have any questions or require further information, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].

Thank you for your attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]

[Your Date of Birth]

[Your Address]