# Consent for Medical Record Transfer

Date: ______________________

To Whom It May Concern,

I, **[Your Full Name]**, born on **[Date of Birth]**, hereby give my consent for the transfer of my medical records from:

**[Current Healthcare Provider's Name]**
**[Current Healthcare Provider's Address]**
**[Current Healthcare Provider's Phone Number]**

to:

**[New Healthcare Provider's Name]**
**[New Healthcare Provider's Address]**
**[New Healthcare Provider's Phone Number]**

This consent includes the release of all relevant medical information, including but not limited to medical history, test results, and treatment plans. I understand that I have the right to revoke this consent at any time by providing a written notice.

Signature: ________________________

Printed Name: _____________________

Date: _____________________________

Thank you for your prompt attention to this matter.

Sincerely,

**[Your Name]**
[Your Contact Information]