Letter of Authorization for Primary Care Physician Transfer

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], hereby authorize the transfer of my primary care medical records from:

Current Physician Name: [Current Physician's Name]
Current Practice Name: [Current Practice Name]
Current Practice Address: [Current Practice Address]
Phone Number: [Current Physician's Phone Number]

to my new primary care physician:

New Physician Name: [New Physician's Name]
New Practice Name: [New Practice Name]
New Practice Address: [New Practice Address]
Phone Number: [New Physician's Phone Number]

This authorization is effective immediately and will continue until revoked in writing.

Thank you for your attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Date of Birth]
[Your Contact Information]