Medical Records Transfer Authorization for Continuity of Care

Date: _____

To: **[Receiving Healthcare Provider's Name]**
[Receiving Healthcare Provider's Address]
[City, State, Zip Code]

From: **[Your Name]**
[Your Address]
[City, State, Zip Code]
[Your Phone Number]

Subject: Authorization for Medical Records Transfer

Dear [Receiving Healthcare Provider's Name],

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

[Current Healthcare Provider's Name]
[Current Healthcare Provider's Address]
[City, State, Zip Code]

to:

[Receiving Healthcare Provider's Name]
[Receiving Healthcare Provider's Address]
[City, State, Zip Code]

This transfer of records is necessary for the continuity of my care. I request that my complete medical records including, but not limited to, the following information be released:

- Medical history
- Medication records
- Test results
- Any other pertinent medical information

This authorization is effective immediately and will remain in effect until revoked. I understand that I have the right to revoke this authorization at any time by providing written notice to both parties.

Thank you for your prompt attention to this matter.

Sincerely,

_____
[Your Signature]
[Your Printed Name]