Medical Records Transfer Authorization

Date: _____

To: [Receiving Healthcare Provider's Name]

Address: [Receiving Healthcare Provider's Address]

From: [Your Name]

Date of Birth: [Your Date of Birth]

Address: [Your Address]

Phone Number: [Your Phone Number]

Subject: Authorization for Transfer of Medical Records

Dear [Healthcare Provider's Name],

I hereby authorize the release of my medical records and healthcare information from [Current Healthcare Provider's Name] to [Receiving Healthcare Provider's Name]. This authorization is effective immediately and will remain in effect until [Expiration Date].

Details of the information to be released include:

- Medical history
- Treatment and diagnosis records
- Test results
- Prescriptions

I understand that I have the right to revoke this authorization at any time by providing written notice, except where the information has already been disclosed. I also understand that my medical information may be subject to redisclosure by the receiving provider and may no longer be protected by federal privacy regulations.

I appreciate your assistance with this matter.

Sincerely,

_____

[Your Name]

[Your Signature (if sending a hard copy)]