Medical Records Transfer Authorization

Date: [Insert Date]

To: [Recipient's Name]

[Recipient's Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I, [Your Full Name], born on [Your Date of Birth], hereby authorize the transfer of my medical records to [Insurance Company Name] for the purpose of [briefly explain purpose, e.g., processing a claim].

Please provide the complete medical records including but not limited to:

- Medical history
- Diagnosis and treatment plans
- Consultation notes
- Test results

This authorization is valid until [Insert Expiration Date or State "until revoked in writing"].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]