Medical Records Transfer Authorization

Date: _____

To Whom It May Concern,

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

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

to:

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

This authorization includes all medical records related to my care, including but not limited to:

- Medical history
- Lab results
- X-rays and imaging studies
- Progress notes
- Treatment plans

This authorization is valid until I revoke it in writing. I understand that I have the right to inspect and copy my records upon request.

Signature: _____

Name: **[Your Full Name]**

Date: _____

Thank you for your cooperation.