# Medical Records Transfer Authorization

Date: _____

To Whom It May Concern,

I, **[Patient's Full Name]**, born on **[Date of Birth]**, hereby authorize the release of my medical records for the purpose of out-of-state medical procedures.

Please transfer my medical records from:

**[Current Healthcare Provider's Name]**
**[Address]**
**[City, State, Zip Code]**
Phone: **[Phone Number]**

To:

**[New Healthcare Provider's Name]**
**[Address]**
**[City, State, Zip Code]**
Phone: **[Phone Number]**

The records to be released include:

- [Specify type of records, e.g., Complete Medical History]
- [Specify other records, e.g., Test results, Imaging records]

This authorization is valid until **[Expiration Date]** or until revoked in writing by me.

Signature: _____

Name: **[Patient's Full Name]**

Phone Number: **[Patient's Phone Number]**

Email: **[Patient's Email]**

Thank you for your assistance.

Sincerely,

**[Patient's Full Name]**