Medical Records Transfer Authorization

Date: [Insert Date]

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

Dear [Receiving Healthcare Provider's Name],

I, [Patient's Full Name], born on [Patient's Date of Birth], hereby authorize the transfer of my medical records to your facility.

Patient Information:
Name: [Patient's Full Name]
Address: [Patient's Address]
City, State, Zip Code: [City, State, Zip Code]
Phone Number: [Patient's Phone Number]

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

Details of the information to be released include:
[Specify information such as medical history, test results, etc.]

This authorization is valid for [Specify duration or until specific date].

I understand that I have the right to revoke this authorization at any time by submitting a written notice. I also understand that my records may be protected under HIPAA regulations.

Signature: _____
Printed Name: [Patient's Printed Name]
Date: [Insert Date]

Please do not hesitate to contact me at [Patient's Phone Number] if you require any further information.

Sincerely,
[Patient's Full Name]