Medical Records Transfer Authorization

Date: _____

To Whom It May Concern:

I, **[Patient's Full Name]**, born on **[Date of Birth]**, hereby authorize the transfer of my medical records for research purposes as specified below.

Patient ID: [Patient ID]

Research Study Title: [Title of Research Study]

Principal Investigator: [Researcher's Name]

Institution: [Institution Name]

Authorization Details

1. Information to be disclosed: [Specify types of medical records, e.g., lab results, treatment history]
2. Purpose of disclosure: Research study related to [Brief description of study purpose]
3. Expiration of authorization: This authorization will expire on [Expiration Date].

I understand that I have the right to revoke this authorization at any time by providing a written notice to the above-mentioned institution. I also understand that the information disclosed may be subject to re-disclosure and may no longer be protected by federal privacy regulations.

By signing below, I confirm that I have read and understood the purpose and scope of this authorization.

Signature: _____

Printed Name: _____

Date: _____

Contact Information: **[Phone Number]**, **[Email Address]**