Medical Records Transfer Authorization

Patient Information:

Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Recipient Information:

Name of Specialist: _____

Practice Name: _____

Address: _____

Phone Number: _____

Authorization Statement:

I, _____ (Patient's Name), hereby authorize the release of my medical records to the above-mentioned specialist for the purpose of a specialty referral.

This authorization includes the following information:

- Medical history
- Treatment records
- Diagnostic reports

This authorization will remain valid until _____ (date or condition for expiration).

Patient Signature: _____

Date: _____