Medical Records Transfer Authorization

Date: [Insert Date]

To: [Recipient's Name]
[Recipient's Title]
[Recipient's Organization]
[Recipient's Address]
[City, State, Zip Code]

Dear [Recipient's Name],

I, [Your Name], hereby authorize the release of my medical records to [Third Party's Name] for the purpose of [Specify Purpose].

Patient Information:
Name: [Your Full Name]
Date of Birth: [Your Date of Birth]
Address: [Your Address]
Phone Number: [Your Phone Number]

Records to be released:
[Specify the records being released, e.g., all medical records, specific treatments, etc.]

This authorization will remain in effect until [Expiration Date OR "revoked in writing"]. I understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken based on this authorization.

By signing below, I certify that I understand the purpose of this authorization and that I have the right to a copy of the records released.

Sincerely,

_____
[Your Name]
[Your Signature]
[Date Signed]