Patient Transfer Authorization

Date: [Insert Date]

From: [Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

To: [Receiving Medical Facility Name]
[Address]
[City, State, Zip Code]

Dear [Recipient's Name],

I, [Your Name], hereby authorize the transfer of medical care for my patient, [Patient's Full Name], born on [Patient's Date of Birth], to your esteemed facility. This transfer is necessary due to [brief description of reason for transfer].

Please find attached all relevant medical records and information pertaining to the patient's health condition. I trust that you will provide the necessary care and support for [Patient's Name].

If you have any questions or need further information, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].

Thank you for your attention to this matter.

Sincerely,

[Your Name]
[Your Title/Position]
[Your Medical Facility Name]