Patient Transfer Consent Form

Date: [Insert Date]

To Whom It May Concern,

I, [Patient's Full Name], born on [Patient's Date of Birth], hereby consent to my transfer from [Current Facility Name] to [Receiving Facility Name].

I understand that this transfer is necessary for my continued care and treatment. I acknowledge that I have been informed about the reasons for this transfer and the implications thereof.

I authorize the medical staff at both facilities to share my medical information pertinent to my treatment and care during this transfer.

Please find below my details for reference:

- **Medical Record Number:** [Insert Medical Record Number]
- **Current Address:** [Insert Current Address]
- **Phone Number:** [Insert Phone Number]

By signing below, I confirm my consent for this transfer.

Patient's Signature: _____

Date: _____

Witness Signature: _____

Date: _____

Thank you for your attention to this matter.

Sincerely,

[Patient's Name]