Date: [Date]

To: [Name of Current Healthcare Provider/Facility]
Address: [Street Address]
City, State, Zip: [City, State, Zip Code]

RE: AUTHORIZATION TO RELEASE AND TRANSFER MEDICAL RECORDS

Patient Information:
Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Social Security Number (optional): [XXX-XX-XXXX]
Phone Number: [Phone Number]

I hereby authorize the release of my complete medical records to the following healthcare provider/facility:

Transfer Records To:
Name: [Name of New Healthcare Provider/Facility]
Address: [Street Address]
City, State, Zip: [City, State, Zip Code]
Phone: [Phone Number]
Fax: [Fax Number]

Information to be Released:
[ ] Complete Medical Record (all dates and types of service)
[ ] Laboratory Reports
[ ] Imaging/Radiology Reports (X-ray, MRI, CT)
[ ] Immunization Records
[ ] Other: [Specify specific records]

Purpose of Disclosure:
[ ] Transfer of Care / Changing Physicians
[ ] Specialist Consultation
[ ] Legal Purposes
[ ] Personal Use

This authorization shall remain valid for [Number] days from the date of signature unless revoked in writing. I understand that I have the right to revoke this authorization at any time.

_____
Patient/Guardian Signature

_____
Printed Name

_____

Date Signed