Date: [Date]

RE: Patient Medical Records Transfer Authorization

To:
[Releasing Provider/Facility Name]
[Address]
[City, State, Zip Code]
[Phone/Fax Number]

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 recipient:

Send Records To:
[Receiving Provider/Facility Name]
[Address]
[City, State, Zip Code]
[Phone/Fax Number]

Information to be Released:
[ ] All medical records (including lab results, imaging, and notes)
[ ] Records for specific dates: [Insert Date Range]
[ ] Other: [Specify specific records]

Purpose of Disclosure:
[ ] Continued medical care
[ ] Personal use
[ ] Legal purposes
[ ] Insurance claim

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

_____
Patient Signature (or Legal Representative)

_____
Date Signed

Relationship to Patient (if signed by Representative): [Relationship]