Date: [Date]

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

Subject: Authorization for Release and Transfer of Electronic Health Records

Patient Information:
Full Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Social Security Number (Optional/Last 4 digits): [Last 4 Digits]
Phone Number: [Your Phone Number]

Dear Records Department,

I am writing to formally authorize the release and transfer of my complete electronic health records (EHR) to the healthcare provider listed below:

Receiving Provider/Facility: [New Provider Name/Clinic]
Address: [New Clinic Street Address]
City, State, Zip: [City, State, Zip Code]
Phone/Fax: [New Clinic Phone/Fax]
Secure Email/Portal: [Email Address if applicable]

Information to be Released:

- All medical records, including clinical notes and summaries.
- Laboratory, pathology, and diagnostic imaging results.
- Immunization records.
- Medication history and allergy lists.
- [Optional: Specify any other specific data].

This authorization is valid for the purpose of continued medical care and treatment. This consent is valid for [Number] months from the date of signing, unless revoked by me in writing earlier.

Please transmit these records electronically via secure file transfer or fax as soon as possible.

Thank you for your prompt attention to this request.

Sincerely,

_____
[Patient Signature]

[Printed Name]