Current Date: [Date]

TO:
[Current Provider Name or Clinic Name]
[Provider Address]
[City, State, Zip Code]
[Phone/Fax Number]

RE: Request for Transfer of Mental Health Records
Patient Name: [Your Full Name]
Date of Birth: [Your Date of Birth]
Last 4 Digits of SSN (optional): [SSN]

To Whom It May Concern,

I am writing to formally request a copy of my mental health records and/or the transfer of these records to a new provider. This request includes, but is not limited to: intake assessments, treatment plans, progress notes, discharge summaries, and medication history.

Please transfer these records to the following professional:

Recipient Name/Clinic: [New Provider Name]
Address: [New Provider Address]
City, State, Zip Code: [New Provider City, State, Zip]
Phone: [New Provider Phone]
Fax: [New Provider Fax]

This authorization is valid for one year from the date of my signature or until [Specific Date]. I understand that I may revoke this consent in writing at any time.

Please let me know if there are any fees associated with this request or if you require any additional forms to be signed.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Phone Number]
[Your Email Address]