

Date: [Date]

To: [Name of Doctor or Facility Currently Holding Records]

Address: [Street Address]

City, State, Zip: [City, State, Zip Code]

Subject: Authorization for Release and Transfer of Medical Records

Patient Information:

Full Name: [Patient Full Name]

Date of Birth: [MM/DD/YYYY]

Social Security Number (Optional): [Last 4 Digits]

Phone Number: [Your Phone Number]

To Whom It May Concern,

I am writing to formally request a copy of my medical records be transferred to the provider listed below for the purpose of [Reason: e.g., continuing care, moving, second opinion].

Please transfer records to:

Name of Receiving Provider/Facility: [Name]

Address: [Street Address]

City, State, Zip: [City, State, Zip Code]

Phone: [Phone Number]

Fax: [Fax Number]

Information to be released:

☐ Complete Medical Record (including history, office notes, labs, and imaging)

☐ Records for specific dates: [Insert Dates]

☐ Other: [Specify]

I understand that these records may contain sensitive information. This authorization is valid for 90 days from the date of signature unless revoked by me in writing.

Please contact me if there are any fees associated with this request or if you require additional documentation.

Sincerely,

(Signature of Patient or Legal Representative)

[Printed Name]