[Your Full Name]
[Your Date of Birth]
[Your Address]
[Your Phone Number]
[Date]

[Current Doctor or Clinic Name]
[Current Clinic Address]

RE: Authorization for Release of Medical Records

To whom it may concern,

I am writing to formally authorize the release and forwarding of my complete medical records to the specialist clinic listed below:

Recipient Specialist Clinic:
[Name of Specialist/Clinic]
[Clinic Address]
[Clinic Phone/Fax Number]

Please include the following information in the transfer:

- Recent lab results and diagnostic imaging reports
- Consultation notes and treatment history
- Current medication lists and immunization records
- [Specify any other specific documents here]

This authorization is valid for the purpose of continued medical care and specialist consultation. I understand that I may revoke this authorization in writing at any time.

Please contact me at the phone number provided above if there are any fees associated with this request or if additional forms are required.

Sincerely,

_____
[Your Signature]

[Your Printed Name]