Date: [Date]

To: [Current Pediatrician/Doctor Name]
[Current Clinic Name]
[Current Clinic Address]

Subject: Authorization to Transfer Medical Records

Patient Name: [Child's Full Name]
Date of Birth: [Child's Date of Birth]

Dear Records Department,

I am writing to formally request a complete copy of the medical records for the patient listed above be forwarded to the following pediatric specialist:

Specialist Name: [Specialist Name]
Facility Name: [Specialist Clinic/Hospital Name]
Address: [Specialist Mailing Address]
Fax Number: [Specialist Fax Number]
Email/Portal (if applicable): [Specialist Email]

Please include all clinical findings, diagnostic test results (including imaging and lab reports), immunization records, and any relevant consultation notes regarding [Specific Condition, if applicable].

This authorization is valid for [Number] months from the date of my signature. Please contact me at [Your Phone Number] if there are any forms to sign or fees required to complete this transfer.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]
[Relationship to Patient]