Consent to Transfer Medical Files

I, _____, hereby authorize the release and transfer of my medical records as described below.

Date of Birth: _____

From (Current Provider):
Name: _____
Address: _____
Phone: _____

To (Receiving Provider):
Name: _____
Address: _____
Phone: _____

Information to be Transferred:
☐ All Medical Records
☐ Specific Records (please specify): _____

I understand that this consent remains valid for 12 months from the date signed unless revoked in writing.

Signature: _____

Date: _____