Healthcare Transfer Acceptance

Subject: Acceptance of Transfer to [Medical Facility Name]

Dear [Doctor/Administrator's Name],

I hereby accept the transfer of my medical care to [Medical Facility Name] effective [Date]. I understand and agree to the transfer of my medical records and ongoing treatment plan.

I acknowledge that:

- All medical records will be transferred securely
- My current treatment plan will be reviewed by the new medical team
- I will schedule an initial consultation within [timeframe]
- Insurance coverage and billing arrangements have been verified

I appreciate the coordination between facilities to ensure continuity of care. Please confirm receipt of this acceptance and provide any additional paperwork required for the transfer process.

I look forward to continuing my treatment at your facility.

Sincerely,

[Patient Name]

[Date of Birth]

[Patient ID/Insurance Information]