[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

Dear [Patient Name],

We understand that you are transitioning your care to a new provider. To ensure a smooth transition and continuity of care, we wish to assist in the transfer of your medical documentation.

A medical records release form is enclosed to facilitate the transfer of your health history to your new doctor. Please complete, sign, and return this form to our office at your earliest convenience.

Once we receive the signed authorization, we will forward your records directly to the specified physician.

If you have any questions regarding this process, please contact our office at [Phone Number].

Sincerely,

[Doctor/Staff Name]
[Practice Name]

Enclosure: Medical Records Release Form