[Current Date]

[Current Physician's Name]
[Current Clinic/Practice Name]
[Clinic Address]
[City, State, Zip Code]

RE: Transfer of Care for [Patient Full Name]
Date of Birth: [Patient Date of Birth]

Dear Dr. [Physician Last Name],

I am writing to formally request a transfer of my medical care from your practice to a new provider. This decision is effective as of [Date].

Please transfer my complete medical records, including diagnostic test results, imaging reports, immunization records, and treatment plans, to the following provider:

[New Physician's Name]
[New Clinic/Practice Name]
[New Clinic Address]
[New Clinic Phone Number]
[New Clinic Fax Number]

I have attached a signed medical records release authorization form to this letter to facilitate this transfer. Please let me know if there are any fees associated with this request or additional documentation required.

Thank you for the care you have provided me in the past.

Sincerely,

[Patient Signature]
[Patient Printed Name]
[Patient Phone Number]