[Your Full Name]
[Your Date of Birth]
[Your Address]
[Your Phone Number]
[Date]

[Current Provider Name or Clinic Name]
[Current Provider Address]
[City, State, Zip Code]

RE: Notice of Primary Care Provider Change and Request for Medical Records

To Whom It May Concern,

I am writing to formally notify you that I am changing my Primary Care Provider (PCP). Effective [Date], I will be receiving my primary medical care from a new provider.

My new provider's information is as follows:

New Provider Name: [New Doctor Name]
Clinic Name: [New Clinic Name]
Address: [New Clinic Address]
Phone Number: [New Clinic Phone Number]
Fax Number: [New Clinic Fax Number]

I request that a complete copy of my medical records, including diagnostic test results, immunization records, and treatment plans, be transferred to the new provider listed above.

Please let me know if there are any specific authorization forms I need to sign or if there are fees associated with this transfer. I would appreciate it if this transfer could be completed by [Desired Date].

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

Sincerely,

[Signature]
[Printed Name]