

Date: [Date]

To: [Current Doctor/Clinic Name]

Address: [Street Address]

City, State, Zip: [City, State, Zip Code]

Phone/Fax: [Phone or Fax Number]

RE: Request for Comprehensive Medical Records

Patient Name: [Full Name]

Date of Birth: [MM/DD/YYYY]

Social Security Number (Optional): [Last 4 Digits]

To Whom It May Concern,

I am writing to formally request a complete copy of my medical records to be transferred to my new healthcare provider. Please include all comprehensive information, including but not limited to:

- Clinical summaries and office visit notes
- Diagnostic test results (Labs, X-rays, MRIs, CT scans)
- Immunization records
- Current and past medication lists
- Surgical reports and hospital discharge summaries
- Problem lists and allergy information

Please transfer these records to:

Provider Name: [New Doctor Name]

Facility Name: [New Clinic/Hospital Name]

Address: [New Street Address]

City, State, Zip: [City, State, Zip Code]

Fax Number: [New Fax Number]

I authorize the release of these records for the purpose of continuing my medical care. Please let me know if there are any administrative fees associated with this request or if additional authorization forms are required.

Thank you for your prompt attention to this matter.

Sincerely,

[Patient or Legal Guardian Signature]

Print Name: [Full Name]

Phone Number: [Your Phone Number]