Date: [Date]

To: [Current Doctor/Clinic Name]
Address: [Current Clinic Address]
Phone/Fax: [Current Clinic Phone/Fax]

RE: Medical Records Release and Patient Transition

Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Social Security Number (Optional): [Last 4 Digits]

To Whom It May Concern,

I am writing to formally request the release of my complete medical records to a new healthcare provider. I have decided to transition my care to the following physician/facility:

New Provider Name: [New Doctor Name]
Facility Name: [New Clinic/Hospital Name]
Address: [New Clinic Address]
Phone: [New Clinic Phone]
Fax: [New Clinic Fax]

Please include all pertinent information, including but not limited to:

- Office visit notes and consultation reports
- Laboratory and diagnostic test results
- Imaging reports (X-ray, MRI, CT)
- Immunization records
- Current medication list and allergy information
- Problem lists and surgical history

I authorize the release of these records via [Secure Email / Fax / Mail]. Please notify me if there are any administrative fees associated with this request or if additional authorization forms are required.

Thank you for the care you have provided me in the past. I would appreciate the transfer of these records by [Date] to ensure continuity of my medical care.

Sincerely,

____
[Patient Signature or Legal Representative]

[Printed Name]
[Phone Number]