

[Your Name]
[Your Address]
[Your Phone Number]
[Date]

[Current Physician Name]
[Practice Name]
[Address]

RE: Notice of Insurance Change and Records Transfer Request

Patient Name: [Your Name]

Date of Birth: [Your Date of Birth]

Dear Dr. [Physician Last Name],

I am writing to inform you that due to a change in my health insurance coverage, I will be transitioning my primary care to a provider within my new network, effective [Date].

I would like to request a formal transfer of my medical records to my new physician:

New Physician Name: [New Doctor Name]
Clinic/Practice Name: [New Practice Name]
Address: [New Practice Address]
Phone/Fax: [New Practice Phone/Fax]

Please include my complete medical history, including recent lab results, immunization records, current medications, and any specialist consultation reports.

Please let me know if there are any specific authorization forms I need to sign or if there is a fee associated with this transfer. I would appreciate the transfer being completed by [Date].

Thank you for the care you have provided me.

Sincerely,

[Your Signature]

[Your Printed Name]