Date: [Date]

Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Patient ID/MRN: [ID Number]

To: [New Provider Name/Department]
[Clinic/Hospital Name]
[Address]

Subject: Reassignment of Multiple Sclerosis Care

Dear [New Provider Name],

I am writing to formally request the transfer and reassignment of my Multiple Sclerosis (MS) care to your practice, effective [Date].

I was diagnosed with [Type of MS, e.g., Relapsing-Remitting MS] in [Year]. My current treatment regimen includes [Current Medication/DMT Name]. My last neurological evaluation was on [Date], and my most recent MRI was completed on [Date] at [Facility].

The reason for this reassignment is [Reason: e.g., relocation, change in insurance, or preference for a specialist within this facility].

I have authorized my previous provider, [Previous Doctor Name] at [Previous Clinic], to release my complete medical records, including diagnostic imaging, laboratory results, and infusion/medication history, to your office. Please let me know if any additional documentation is required to facilitate this transition.

I look forward to discussing my ongoing treatment plan and managing my symptoms under your care. I will contact your office to schedule my initial intake appointment.

Sincerely,

[Your Signature]
[Your Printed Name]
[Phone Number]
[Email Address]