Date: [Date]

To: [Current Physician Name]
[Clinic/Facility Name]
[Address]
[City, State, Zip Code]

Re: Patient Records Transfer Request

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

Dear Dr. [Current Physician Last Name],

I am writing to formally notify you that I am changing my primary treating physician. I have decided to transfer my medical care to a new provider effective [Date].

Please transfer a complete copy of my medical records, including but not limited to: clinical notes, lab results, diagnostic imaging reports, immunization records, and current medication lists to my new physician:

New Physician Name: [New Physician Name]
Practice Name: [New Clinic Name]
Address: [New Clinic Address]
Phone: [Phone Number]
Fax: [Fax Number]

I have enclosed a signed authorization form for the release of these records. Please let me know if there are any fees associated with this transfer or if further documentation is required.

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

Sincerely,

[Patient Signature]

[Patient Printed Name]
[Phone Number]