Date: [Insert Date]

TO:
[Name of Releasing Doctor/Facility]
[Address]
[Phone/Fax Number]

RE: URGENT MEDICAL RECORD TRANSFER
Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Social Security Number (Optional): [Last 4 Digits]

Dear Records Department,

I am writing to formally request the **urgent** transfer of my complete medical records to the provider listed below. This request is time-sensitive due to an upcoming procedure/consultation scheduled for [Date].

Please include all records, including but not limited to:

- Clinical summaries and office notes
- Laboratory and pathology results
- Imaging reports (X-ray, MRI, CT)
- Immunization records
- Current medication lists

Please transfer records to:

[Name of Receiving Doctor/Facility]
[Address]
[City, State, Zip Code]
[Fax Number for Records]
[Phone Number]

I hereby authorize the release of these records for the purpose of continuing medical care. I understand that this may include information regarding sensitive diagnostics if applicable.

Due to the urgency of my medical situation, please confirm receipt of this request and provide an estimated time for the transfer. You may contact me directly at [Your Phone Number] if there are any issues or fees required for this expedited request.

Thank you for your immediate attention to this matter.

Sincerely,

_____
[Signature of Patient or Legal Guardian]
[Printed Name]