[Your Full Name]
[Your Date of Birth]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

[Recipient Name or Medical Records Department]
[Name of Current Clinic/Hospital]
[Address of Clinic/Hospital]

RE: Patient Health Records Transfer Request

Dear Medical Records Department,

I am writing to formally request a complete copy of my medical records to be transferred from your facility to the healthcare provider listed below.

Records to be released:
[ ] All medical records (including lab results, imaging reports, and clinical notes)
[ ] Records for the period of [Start Date] to [End Date]
[ ] Specific records only: [List specific documents]

Please send the records to:
[Name of New Doctor/Facility]
[Address of New Facility]
[Phone Number/Fax Number]
[Email Address if applicable]

I understand that there may be a fee associated with this request. Please contact me if the cost exceeds [Amount].

This authorization is valid for [Number] days from the date of my signature. I understand that I may revoke this authorization in writing at any time.

Thank you for your prompt attention to this matter.

Sincerely,

_____
[Your Signature]

[Your Printed Name]
[Last 4 Digits of SSN - Optional]