Date: [Date]

To: [Recipient Name/Clinic Name]
Address: [Recipient Address]
Fax/Email: [Recipient Contact Info]

RE: Request for Patient Medical Records

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

Dear Medical Records Department,

The above-named patient is currently under the care of [Physician Name] at [Your Clinic Name]. To ensure continuity of care and appropriate treatment planning, we kindly request a copy of the patient's medical history.

Please provide the following records from [Start Date] to [End Date]:

- Problem list and diagnosis history
- Recent consultation notes and progress reports
- Laboratory and diagnostic test results
- Current medication list and immunization records
- Operative reports and discharge summaries

Attached to this request is a signed authorization form from the patient permitting the release of these records to our facility.

Please send the requested documents via fax to [Fax Number] or via secure email to [Email Address].

Thank you for your prompt assistance in this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Role]
[Your Clinic Name]
[Your Phone Number]