

Date: [Date]

To: [Previous Provider Name or Clinic Name]

Address: [Previous Provider Address]

Phone/Fax: [Previous Provider Phone/Fax Number]

RE: Patient Medical Records Request

Patient Name: [Full Name]

Date of Birth: [MM/DD/YYYY]

Social Security Number (Optional): [Last 4 Digits]

To whom it may concern,

I am writing to formally request a copy of my medical records. Please transfer my complete medical file, including but not limited to: clinical notes, lab results, diagnostic imaging reports, immunization records, and medication history.

Please send these records to my new healthcare provider at the following address:

New Provider Name: [New Doctor Name]

Facility Name: [New Clinic/Hospital Name]

Address: [New Provider Address]

Fax Number: [New Provider Fax Number]

I understand that there may be a fee associated with this request. Please notify me in advance if the cost exceeds [Enter Dollar Amount].

Thank you for your prompt attention to this matter.

Sincerely,

[Patient or Legal Representative Signature]

Print Name: [Name]