Date: [Insert Date]

To: [Recipient Name/Clinic Name]
Address: [Recipient Street Address]
City, State, Zip: [City, State, Zip Code]

RE: Request for Transfer of Medical Records

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

To Whom It May Concern,

This letter serves as a formal request to transfer the medical records of the aforementioned patient to our facility. The patient is now under our care, and their previous medical history is required for continued treatment.

Please provide the following records:

- Complete medical history and clinical notes
- Laboratory and diagnostic test results
- Imaging reports (X-ray, MRI, CT scans)
- Immunization records
- Current medication list and allergy information

Attached to this letter, please find the signed Authorization for Release of Information form executed by the patient.

Please send the records via one of the following methods:

Mail: [Your Clinic Name, Address, City, State, Zip]
Fax: [Your Fax Number]
Secure Email: [Your Secure Email Address]

If there are any fees associated with this request or if further information is needed, please contact our office at [Your Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Signature]
[Printed Name of Requestor]
[Title/Position]
[Clinic Name]