Date: [Insert Date]

From:
[Sending Provider Name]
[Facility Name]
[Address]
[Phone Number]

To:
[Receiving Provider Name]
[Facility Name]
[Address]

Subject: Transfer of Patient Health Information

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

Dear [Receiving Provider Name],

The patient named above is being transferred to your care for [reason for transfer/further management]. To ensure continuity of care, please find the enclosed clinical records and health information.

Clinical Summary:

- Current Diagnosis: [Primary Diagnosis]
- Current Medications: [List Medications]
- Known Allergies: [List Allergies]
- Recent Lab Results/Imaging: [Summary of Results]

Attached Documents:

- Discharge Summary
- Problem List
- Immunization Records
- Diagnostic Test Reports

If you require any further information regarding this patient's medical history or current treatment plan, please contact our office at [Phone Number].

Sincerely,

[Signature]
[Printed Name]
[Credentials]
[Date]