Date: [Date]

To: [Recipient Provider/Facility Name]
Address: [Recipient Address]
Fax/Phone: [Recipient Fax/Phone]

From: [Requesting Provider Name]
Facility: [Your Clinic/Hospital Name]
Address: [Your Address]
Fax/Phone: [Your Fax/Phone]

RE: Patient Medical Records Request

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

Dear Medical Records Department,

Our office is currently providing medical care for the patient listed above. We are requesting a copy of the following medical records for the purpose of continuing care:

- [ ] All Medical Records
- [ ] Office Visit Notes (Dates: [Range])
- [ ] Lab Results
- [ ] Imaging/Radiology Reports
- [ ] Immunization Records
- [ ] Other: [Specific Description]

Please send these records via fax to **[Your Fax Number]** or mail them to the address listed above.

The patient has signed an authorization for the release of these records, which is attached to this request.

Thank you for your assistance in providing coordinated care for this patient.

Sincerely,

[Your Name/Signature]
[Your Title]