Date: [Insert Date]

To: [Recipient Name/Medical Records Department]
Facility Name: [Name of Releasing Institution]
Fax/Email: [Recipient Fax or Email]

RE: URGENT MEDICAL RECORDS TRANSFER REQUEST

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/SSN: [Insert ID if applicable]

To whom it may concern,

The above-named patient is currently under our care for urgent medical evaluation. We require an immediate transfer of their medical history to ensure continuity of care and informed clinical decision-making.

Please provide the following records via [Fax/Secure Email] as soon as possible:

- Most recent history and physical (H&P)
- Last two discharge summaries
- Recent laboratory and diagnostic imaging results
- Current medication list and allergy profile
- Immunization records

A signed patient authorization for the release of information is [attached/on file].

Please send these records to:

Attention: [Provider Name/Department]
Facility: [Your Facility Name]
Secure Fax: [Your Fax Number]
Phone: [Your Phone Number]

Thank you for your prompt assistance in this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Role]