Date: [Insert Date]

To: [Name of Records Department/Physician]
Facility Name: [Insert Facility Name]
Address: [Insert Address]
Fax/Email: [Insert Contact Information]

RE: URGENT MEDICAL RECORDS REQUEST
Patient Name: [Insert Full Name]
Date of Birth: [Insert Date of Birth]
Patient ID/SSN: [Insert ID Number if applicable]

To Whom It May Concern,

This is an urgent request for the immediate release of medical records for the above-named patient. These records are required for a specialist consultation scheduled for **[Insert Date and Time of Appointment]** with **[Insert Specialist Name]**.

Please provide the following documents from the period of [Start Date] to [End Date]:

- Clinical Progress Notes
- Diagnostic Imaging Reports (MRI, CT, X-Ray)
- Laboratory/Pathology Results
- Specialist Referrals and Previous Consultations
- Current Medication List

Please deliver these records via one of the following methods:

Fax to: [Insert Fax Number] Attention: [Insert Name]
Secure Email: [Insert Email Address]
Patient Pickup: The patient will pick up a physical copy on [Insert Date].

Due to the upcoming appointment, I request that this be processed as a priority. If there are any fees or additional authorization forms required, please contact me immediately at [Insert Phone Number].

Thank you for your prompt assistance in ensuring continuity of care.

Sincerely,

[Your Signature]
[Your Printed Name]
[Relationship to Patient, if applicable]