Date: [Insert Date]

To: [Name of Holding Facility/Physician]
Department: Medical Records Department
Address: [Insert Address]
Phone/Fax: [Insert Phone/Fax Number]

RE: Medical Records Request for Oncology Consultation

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,

I am writing to request a complete copy of my medical records to be transferred to my oncology specialist for a consultation. Please provide the following documentation:

- Recent physician notes and consultation reports
- Diagnostic imaging reports (CT, MRI, PET, Ultrasound)
- Pathology and biopsy reports
- Laboratory and blood work results
- Current treatment plans and medication lists
- Chemotherapy or radiation therapy summaries

Please forward these records to the following specialist:

Recipient Physician: [Name of Oncologist]
Facility Name: [Name of Oncology Clinic/Hospital]
Address: [Insert Address]
Fax Number: [Insert Fax Number]
Email (if applicable): [Insert Email]

I have attached a signed authorization form for the release of protected health information. If there are any fees associated with this request, please notify me in advance. Please process this request urgently as my appointment is scheduled for [Insert Date].

Thank you for your prompt assistance.

Sincerely,

[Signature]
[Printed Name]
[Phone Number]