Date: [Insert Date]

To: [Recipient Name/Medical Records Department]
Facility Name: [Insert Facility Name]
Address: [Insert Address]
Phone/Fax: [Insert Phone/Fax Number]

RE: Patient Medical Records Request
Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Date of Birth]
Patient ID/SSN: [Insert ID Number if applicable]

Dear Medical Records Department,

I am writing to formally request a copy of my medical records to be transferred to my Internal Medicine Specialist for a consultation. Please provide all pertinent clinical information, including but not limited to:

- Complete medical history and physical exam notes
- Most recent laboratory results (blood work, urinalysis, etc.)
- Diagnostic imaging reports (X-rays, CT scans, MRIs, Ultrasounds)
- Electrocardiogram (ECG/EKG) tracings and reports
- Current medication list and immunization records
- Discharge summaries or specialist consultation reports

Please forward these records to:

Physician Name: [Insert Internal Medicine Specialist Name]
Clinic Name: [Insert Clinic Name]
Address: [Insert Clinic Address]
Fax Number: [Insert Clinic Fax Number]
Email (if applicable): [Insert Clinic Email]

I have attached a signed authorization form for the release of protected health information. Please notify me if there are any fees associated with this request or if additional documentation is required.

Thank you for your prompt assistance with this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Phone Number]