Date: [Date]

To: [Previous Clinic/Doctor Name]
Address: [Previous Clinic Address]
Phone/Fax: [Previous Clinic Phone/Fax]

RE: REQUEST FOR TRANSFER OF MEDICAL RECORDS

Patient Information:
Full Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Social Security Number (Optional): [Last 4 Digits]
Phone Number: [Patient Phone Number]

To Whom It May Concern,

I am writing to formally request a copy of my medical records to be transferred from your facility to the provider listed below:

New Provider Name: [New Clinic/Doctor Name]
Address: [New Clinic Address]
Phone Number: [New Clinic Phone]
Fax Number: [New Clinic Fax]

Please include the following records for the period of [Start Date] to [End Date/Present]:

- Problem list and diagnosis
- Lab reports and imaging results
- Immunization records
- Current medications and treatment plans
- Progress notes

I authorize the release of these records for the purpose of continuing my medical care. Please inform me if there are any administrative fees associated with this request or if additional authorization forms are required.

Thank you for your prompt attention to this matter.

Sincerely,

____
[Patient or Legal Guardian Signature]

[Printed Name of Patient/Guardian]