Date: [Date]

RE: Request for Transfer of Electronic Health Records (EHR)

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Patient ID/SSN: [Patient ID Number]
Phone Number: [Patient Phone Number]

To: [Previous Clinic/Doctor Name]
[Previous Clinic Address]
[City, State, Zip Code]
[Fax/Email if applicable]

To Whom It May Concern,

I am writing to formally request the transfer of my complete Electronic Health Records (EHR) to my new primary care provider. Please include all digital files, including medical history, clinical notes, immunization records, lab results, imaging reports, and current medication lists.

Please transfer the records to the following provider:

New Clinic Name: [New Clinic Name]
Provider Name: [New Doctor Name]
Address: [New Clinic Address]
City, State, Zip Code: [City, State, Zip Code]
Fax Number: [New Clinic Fax]
Secure Email/Portal: [New Clinic Email]

I authorize the release of these records for the purpose of continuing my medical care. Please process this transfer in accordance with HIPAA regulations.

Thank you for your prompt attention to this request.

Sincerely,

____
[Patient or Legal Guardian Signature]

[Printed Name]