Date: [Date]
To: [Recipient Clinic/Facility Name]
Department: Records/Radiology Department
Address: [Clinic Address]

Subject: Request for Radiographic Imaging Records

To whom it may concern,

Our clinic is currently providing care for the patient listed below. To ensure continuity of care and accurate clinical assessment, we kindly request the release of their radiographic imaging records.

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/Chart Number: [If applicable]

Records Requested:

- Imaging Reports (PDF/Digital format)
- Original Images (DICOM files via cloud link or CD)
- Specific Studies: [e.g., Chest X-ray, MRI Lumbar Spine, Dental Panorex]
- Date(s) of Service: [Insert Date or Range]

Please deliver these records via the following method:

- **Secure Email:** [Clinic Email Address]
- **Fax:** [Clinic Fax Number]
- **Cloud Portal:** [Link/Instructions if applicable]

A signed patient authorization for the release of medical information is attached to this request.

Thank you for your prompt assistance. If there are any fees or if further information is required, please contact our office at [Clinic Phone Number].

Sincerely,

[Doctor/Provider Name]
[Clinic Name]
[Clinic Address]