Date: [Insert Date]

To: [Recipient Name/Department]
Clinic Name: [Recipient Clinic Name]
Fax/Email: [Recipient Fax or Email Address]

RE: Request for Genetic Testing Results

Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Patient ID/MRN: [Patient Medical Record Number]

Dear [Recipient Name or Records Department],

Our clinic is currently providing care for the above-mentioned patient. We are requesting copies of the following genetic testing reports performed at your facility:

- [Specific Test Name, e.g., Whole Exome Sequencing]
- [Specific Test Name, e.g., BRCA1/BRCA2 Panel]
- All relevant clinical notes and genetic counseling summaries.

Please forward these documents to our office via secure fax at [Your Fax Number] or via secure email at [Your Email Address].

Attached to this request, please find the signed Patient Authorization for Release of Medical Information.

Thank you for your assistance in ensuring the continuity of care for this patient. If you have any questions, please contact our office at [Your Phone Number].

Sincerely,

[Your Name]
[Your Title/Position]
[Your Clinic Name]