

Date: [Date]

To: Radiology Records Department

Facility Name: [Sending Facility Name]

Address: [Facility Address]

Fax/Email: [Facility Fax or Email]

RE: RADIOLOGY RECORDS REQUEST FOR PATIENT TRANSFER

Patient Name: [Patient Full Name]

Date of Birth: [Date of Birth]

Patient ID/MRN: [Patient Medical Record Number]

Dear Records Manager,

Please provide a copy of the following radiology records for the patient listed above for the purpose of transferring care to our facility.

Requested Records:

- Diagnostic Imaging Reports (X-ray, CT, MRI, Ultrasound, etc.)
- Original DICOM Images (on CD or via electronic transfer)
- Relevant Clinical Notes and Lab Results

Date Range: [Specific Dates or "All Records"]

Delivery Instructions:

Please send the records via the following method:

Electronic Transfer/PACS Link: [Link/Email]

Secure Fax: [Fax Number]

Mail/Courier to: [Receiving Facility Name and Address]

A signed patient authorization for the release of medical information is [attached/on file].

Thank you for your prompt assistance in ensuring the continuity of patient care.

Sincerely,

[Your Name/Signature]

[Your Title]

[Receiving Facility Name]

[Phone Number]