Date: [Date]

To: [Imaging Facility Name]
Address: [Facility Address]
Phone/Fax: [Facility Phone/Fax]

RE: Patient Medical Records Request
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Patient ID/MRN: [Patient ID Number]

To Whom It May Concern,

For the purpose of continuity of care, I am requesting the release of the following diagnostic imaging records for the patient listed above:

- **Study Type(s):** [e.g., MRI Lumbar Spine, CT Chest, X-Ray Left Knee]
- **Date(s) of Service:** [Dates or Date Range]
- **Required Materials:** Radiology Reports and DICOM Images (on CD or via Digital Transfer)

Please deliver these records to the following healthcare provider:

Provider Name: [Receiving Doctor Name]
Clinic Name: [Receiving Clinic Name]
Address: [Delivery Address]
Fax: [Clinic Fax Number]

If there are any forms or authorizations required to complete this request, please contact our office immediately at [Your Phone Number].

Thank you for your assistance in providing timely care for this patient.

Sincerely,

[Your Name/Signature]
[Your Title/Office Name]