Date: [Date]

To: [Previous Physician or Clinic Name]
Address: [Street Address]
City, State, Zip: [City, State, Zip Code]
Phone/Fax: [Phone or Fax Number]

RE: Request for Pediatric Immunization Records

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Parent/Guardian Name: [Parent/Guardian Name]

To Whom It May Concern,

I am writing to request a complete copy of the immunization records for the patient listed above. The patient has recently transferred to our practice, and we require these records to ensure their vaccinations are up to date and to maintain an accurate medical history.

Please send the records via fax to [Your Fax Number] or by mail to the following address:

[Your Clinic Name]
[Attn: Records Department]
[Your Street Address]
[Your City, State, Zip Code]

Attached to this letter is a signed HIPAA-compliant authorization for the release of medical information.

Thank you for your prompt assistance with this transition of care.

Sincerely,

[Your Name/Signature]
[Your Title/Office Position]
[Your Phone Number]