Date: [Date]

To: [Name of Current/Previous Provider or Clinic]
Address: [Provider Address]
Phone/Fax: [Provider Phone/Fax Number]

Re: Continuity of Care Records Request
Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
SSN (Optional): [Patient Last 4 Digits of SSN]

To Whom It May Concern,

I am writing to formally request a copy of my mental health records for the purpose of ensuring continuity of care with a new provider. Please transition my clinical information to the professional listed below:

Receiving Provider Name: [New Provider Name]
Clinic Name: [New Clinic Name]
Address: [New Provider Address]
Fax Number: [New Provider Fax Number]
Email: [New Provider Email]

Please include the following records from the period of [Start Date] to [End Date/Present]:

- Intake Assessments and Diagnostic Summaries
- Treatment Plans and Progress Notes
- Medication History and Management Records
- Discharge Summary
- Laboratory/Test Results

I understand that these records may contain sensitive information regarding mental health, substance use, or HIV/AIDS status. I expressly authorize the release of these specific records to facilitate my ongoing treatment.

Please let me know if there are any specific forms required to complete this process or if there are any associated fees. Thank you for your prompt assistance in coordinating my care.

Sincerely,

[Signature]
[Printed Name]
[Phone Number]