

Date: [Date]

To: [Recipient Physician Name]

Facility Name: [Recipient Clinic/Hospital]

Fax/Address: [Recipient Fax Number or Address]

From: [Requesting Physician Name]

Facility Name: [Your Clinic/Hospital]

Phone: [Your Phone Number]

Fax: [Your Fax Number]

RE: REQUEST FOR MEDICAL RECORDS

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Patient ID/SSN: [ID Number, if applicable]

Dear Dr. [Recipient Last Name],

The above-named patient is currently under my care. To ensure continuity of care and a comprehensive clinical evaluation, I am requesting copies of the following medical records:

- Most recent History and Physical
- Last 3 Progress Notes
- Recent Laboratory Results
- Imaging Reports (X-ray, MRI, CT)
- Consultation Reports
- Immunization Records
- [Other: Specify additional records]

Please transmit these records via fax to **[Your Fax Number]** or mail them to the address listed above.

Attached to this request is a signed Authorization for Release of Information by the patient. If you have any questions, please contact my office at [Your Phone Number].

Thank you for your assistance in the care of this patient.

Sincerely,

[Signature]

[Requesting Physician Name, Degree]

[Medical License Number]