

[Your Name]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

[Current Doctor's Name]
[Clinic/Hospital Name]
[Clinic/Hospital Address]

RE: Request for Medical Records for [Patient Name] (DOB: [Date of Birth])

Dear Dr. [Doctor's Last Name],

I am writing to formally request a complete copy of my medical records. I have decided to seek a second opinion regarding my current diagnosis and treatment plan for [mention condition/symptoms].

Please provide the following documents:

- Clinical notes and consultation summaries
- Laboratory test results
- Imaging reports (X-rays, MRIs, CT scans)
- Pathology reports
- Current medication list and immunization history

Please send these records directly to the following physician's office:

[Consulting Doctor's Name]
[Consulting Doctor's Practice Name]
[Consulting Doctor's Address]
[Consulting Doctor's Fax/Email]

If there is a specific authorization form required by your office, or if there are any administrative fees associated with this request, please let me know as soon as possible.

Thank you for your assistance and for the care you have provided.

Sincerely,

[Your Signature]
[Your Printed Name]