

Date: [Date]
From: [Sending Clinic Name]
Address: [Sending Clinic Address]
Phone: [Sending Clinic Phone Number]

To: [Receiving Clinic Name]
Attention: [Doctor's Name / Medical Records Department]
Address: [Receiving Clinic Address]
Fax/Email: [Receiving Clinic Fax or Email]

RE: Transfer of Medical Records

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/Chart Number: [ID Number, if applicable]

To Whom It May Concern,

Please find enclosed the medical records for the above-mentioned patient. This transfer is being performed [at the patient's request / due to a referral / due to a change in primary care provider].

The attached records include:

- Medical History and Progress Notes
- Current Medication List and Immunization Records
- Recent Lab Results and Diagnostic Imaging Reports
- Problem List and Allergies
- [List any other specific documents]

A signed Authorization for Release of Information is [attached/on file].

Please update your records accordingly. If you have any questions or require further information regarding this patient's history, please contact our office at [Phone Number].

Sincerely,

[Signature]
[Name of Clinician or Records Clerk]
[Title]
[Sending Clinic Name]