Date: [Date]

RE: Continuity of Care and Medical Records Transfer
Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Diagnosis: [Primary Chronic Illness]

To: [Receiving Provider/Clinic Name]
Address: [Provider Address]

Dear [Provider Name],

I am writing to formally request the transfer of medical responsibility and establish continuity of care for the aforementioned patient, who is being managed for [Specific Chronic Condition(s)].

The patient has been under my care since [Start Date] for the management of [Description of Condition]. To ensure a seamless transition and safety in treatment, I have attached the following records:

- Current Problem List and Medical History
- Latest Comprehensive Care Plan
- Current Medication List (including dosages and frequencies)
- Most recent Lab Results and Diagnostic Imaging
- Immunization Records
- Summary of Recent Consultations

Clinical Summary:
[Briefly describe the current status of the patient, recent flare-ups, or specific treatment goals].

Pending Actions/Follow-ups:
[List any upcoming tests, referrals, or medication adjustments required].

Please contact my office at [Phone Number] or via [Email/Portal] if you require further clarification regarding this patient's history or treatment protocol.

Sincerely,

[Your Name/Signature]
[Your Title/Credentials]
[Facility Name]