URGENT: CONTINUITY OF CARE MEDICAL RECORD REQUEST

Date: [Date]

To: [Recipient Name/Facility Name]
Department: Medical Records / Health Information Management
Fax/Email: [Recipient Fax or Email]

RE: Patient Information
Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Patient ID/SSN (Last 4): [Optional ID]

To Whom It May Concern,

This is an urgent request for the immediate release of medical records for the patient listed above. This information is required for **Continuity of Care** and is needed for an upcoming appointment/procedure scheduled on **[Date of Appointment]**.

Please provide the following records from **[Start Date]** to **[End Date]**:

- Discharge Summary
- Latest Progress Notes
- Laboratory Results
- Radiology/Imaging Reports
- Current Medication List
- Operative Reports (if applicable)

Please deliver these records via one of the following methods:

- **Secure Fax:** [Your Fax Number]
- **Secure Email:** [Your Email Address]

A signed Patient Authorization for Release of Information is attached to this request. If there are any issues or if further information is required, please contact our office immediately at [Your Phone Number].

Thank you for your prompt assistance in ensuring this patient's care is not delayed.

Sincerely,

[Your Name/Signature]
[Your Title/Organization]
[Your Phone Number]