Date: [Insert Date]

To: [Name of Supplying Hospital/Clinic]
Department: [e.g., Medical Records Department]
Address: [Insert Address]

RE: COMPREHENSIVE MEDICAL RECORD REQUEST FOR PATIENT TRANSFER

Patient Name: [Insert Full Name]
Date of Birth: [Insert DOB]
Patient ID/SSN: [Insert ID Number]
Phone Number: [Insert Phone Number]

To Whom It May Concern,

I am writing to formally request a comprehensive copy of my complete medical records. I am transitioning my care to a new healthcare provider and require these documents to ensure continuity of care.

Please provide all records pertaining to my care, including but not limited to:

- Detailed Physician Progress Notes and Consultation Reports
- Complete Laboratory, Pathology, and Diagnostic Test Results
- Radiology Reports and Imaging Files (DICOM format if possible)
- Discharge Summaries and Operative Reports
- Current Medication Lists and Immunization Records
- Treatment Plans and Problem Lists

Please transfer these records to my new provider at the following address:

Provider Name: [Name of Receiving Physician/Facility]
Address: [Insert New Facility Address]
Phone/Fax: [Insert Contact Info]

I have attached a signed Authorization for Release of Information form. If there are any administrative fees associated with this request, please notify me in advance.

Thank you for your prompt assistance in this matter.

Sincerely,

[Your Signature]
[Your Printed Name]