[Your Name]
[Your Date of Birth]
[Your Phone Number]
[Your Address]

[Date]

[Name of Out-of-State Facility/Hospital]
[Department Name, e.g., Radiology Records]
[Facility Address]
[City, State, Zip Code]

RE: Request for Diagnostic Imaging and Reports

To Whom It May Concern,

I am writing to formally request a copy of my diagnostic imaging studies and the corresponding formal radiologist reports performed at your facility. I require these records for continuing care with my local physician.

Patient Information:
Name: [Your Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/MRN (if known): [ID Number]

Records Requested:
Study Type(s): [e.g., MRI Lumbar Spine, CT Chest, X-Ray]
Approximate Date(s) of Service: [Date or Date Range]

Please provide the images in **DICOM format** (via digital download link or CD/USB) and include the **written interpretation reports** in PDF format.

Delivery Instructions:
Please send the records to:
[Recipient Name/Doctor Office]
[Mailing Address or Secure Email]
[Fax Number for Reports Only]

Please contact me at [Your Phone Number] if there are any authorization forms I need to sign or if there are fees associated with this request. Thank you for your prompt assistance.

Sincerely,

[Your Signature]

[Your Printed Name]