[Your Name]
[Your Address]
[Your City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[Medical Records Department Name]
[Out-of-State Facility Name]
[Facility Address]
[Facility City, State, Zip Code]

RE: Request for Medical Records for Chronic Disease Management
Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/Account Number (if known): [ID Number]

To Whom It May Concern,

I am writing to formally request a copy of my medical records for the purpose of ongoing chronic disease management with my current healthcare provider.

Please provide records related to the treatment of [Name of Chronic Condition] for the period of [Start Date] to [End Date]. Specifically, I am requesting:

- Progress notes and clinical summaries
- Laboratory and diagnostic test results
- Imaging reports (X-ray, MRI, CT scans)
- Current medication lists and treatment plans
- Immunization records

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

[New Doctor Name]
[New Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Fax Number, if applicable]

I have attached a signed HIPAA authorization form to this request. If there are any fees associated with this duplication, please notify me in advance. If you have any questions, please contact me at [Your Phone Number].

Thank you for your prompt assistance in ensuring the continuity of my care.

Sincerely,

[Your Signature]

[Your Printed Name]