

Date: [Date]

TO: [Recipient Name/Clinic Name]

Address: [Recipient Address]

Phone/Fax: [Recipient Phone/Fax]

RE: Patient Records Transfer

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Patient ID/MRN: [Patient ID Number]

Dear [Doctor Name/Medical Records Department],

The above-named patient is currently under our care and has requested the transfer of their medical records to your facility for [Reason for Transfer: e.g., Continued Obstetric Care / Gynecological Consultation / Specialist Management].

Please find the following documents enclosed/attached:

- Comprehensive Medical History and Physical Exams
- Obstetric History (GTPAL) and Prenatal Flowsheets
- Recent Laboratory Results (including Pap smear, STI screening, and blood work)
- Imaging Reports (Ultrasounds, Mammograms, or Pelvic Scans)
- Current Medications and Allergy List
- Operative Reports (if applicable)

If you require any additional information regarding this patient's history or treatment plan, please contact our office at [Your Clinic Phone Number].

Thank you for your assistance in ensuring the continuity of care for this patient.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Title]

[Your Clinic Name]