

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

[Date]

[Current OB/GYN Practice Name]
[Doctor's Name]
[Practice Address]

RE: Authorization to Release Medical Records

To Whom It May Concern,

I am writing to formally request a copy of my medical records to be transferred due to my upcoming relocation. Please release all of my obstetric and gynecological records, including but not limited to:

- Prenatal care records and flowsheets
- Surgical reports and pathology results
- Last two years of Pap smear results
- Imaging reports (Ultrasounds, Mammograms, Bone Density)
- Immunization records and laboratory test results

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

[New Doctor/Practice Name]
[New Practice Address]
[New Practice Phone/Fax Number]

If there is a specific authorization form required by your office, or if there are any fees associated with this request, please contact me at the phone number listed above as soon as possible. I would like the transfer to be completed by [Date].

Thank you for your assistance and for the care provided during my time as a patient.

Sincerely,

[Your Signature]

[Your Printed Name]