Date: [Date]

To: [Name of Physician/Facility]
Department: [Department Name, e.g., Gynecology]
Address: [Facility Address]
Fax/Email: [Recipient Fax or Email]

RE: REQUEST FOR MEDICAL RECORDS
Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Patient ID/MRN: [Patient ID Number, if known]

To Whom It May Concern,

I am writing to formally request a copy of my gynecological medical records for the purpose of a specialist consultation with [Name of Specialist].

Please provide the following records from [Start Date] to [End Date]:

- Progress notes and clinical summaries
- Latest Pap smear results and pathology reports
- Ultrasound, Mammogram, or Pelvic imaging reports
- Laboratory and blood work results
- Surgical or procedure reports (if applicable)

Please forward these records via [Secure Email/Fax/Mail] to:

[Name of Specialist/Clinic]
[Clinic Address]
[Clinic Fax Number]
[Clinic Email Address]

Attached is my signed authorization form for the release of protected health information. If there are any fees associated with this request, please notify me in advance.

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

Sincerely,

[Patient Signature]
[Patient Printed Name]
[Phone Number]