Date: [Insert Date]

To: [Name of Previous Physical Therapist/Facility]
Address: [Previous Facility Address]
Phone/Fax: [Previous Facility Phone/Fax]

RE: Medical Records Request for Continuity of Care
Patient Name: [Your Full Name]
Date of Birth: [Your Date of Birth]
Patient ID/Account Number: [If known]

To Whom It May Concern,

I am writing to formally request a copy of my physical therapy records to ensure continuity of care with my new provider. Please release my records to the following healthcare professional:

New Provider Name: [New Physical Therapist/Doctor Name]
Facility Name: [New Facility Name]
Address: [New Facility Address]
Fax Number: [New Facility Fax Number]

Please include the following information from my recent course of treatment:

- Initial Evaluation and Plan of Care
- Progress Reports and Daily Treatment Notes
- Discharge Summary
- Imaging Reports (X-ray, MRI, etc., if applicable)
- Home Exercise Programs

I authorize the release of these records for the purpose of ongoing medical treatment. If there are any forms or fees required to process this request, please notify me immediately at [Your Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Current Address]