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

[Date]

[Current Doctor or Facility Name]
[Department, if applicable]
[Address]

Subject: Authorization to Release and Transfer Medical Records

To Whom It May Concern,

I am writing to formally request a copy of my medical records to be transferred to my orthopedic specialist. Please include all relevant diagnostic reports, office notes, and imaging results (X-rays, MRIs, or CT scans) related to my orthopedic care.

Please send the records to:

[Orthopedic Specialist Name]
[Clinic/Hospital Name]
[Address]
[Phone Number]
[Fax Number]

I authorize the release of these records for the purpose of continuing medical treatment. If there are any forms I need to sign or fees associated with this request, please notify me immediately.

Thank you for your assistance with this matter.

Sincerely,

[Your Signature]
[Your Printed Name]