Date: [Current Date]

To: [Primary Care Physician Name/Facility Name]
Address: [Street Address]
City, State, Zip: [City, State, Zip Code]

RE: Patient Medical Records Request
Patient Name: [Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/Account Number: [Optional ID Number]

Dear Records Department,

I am writing to formally request that a copy of my medical records be forwarded to the specialist listed below for the purpose of a consultation.

Please forward the following records:
[e.g., All records from the past 2 years, specific lab results, imaging reports, or visit summaries]

Please send these records to:
Specialist Name: [Doctor Name]
Facility Name: [Clinic/Hospital Name]
Address: [Street Address]
Fax Number: [Fax Number]
Email/Portal (if applicable): [Email Address]

I have an upcoming appointment scheduled for [Date of Appointment]. I would appreciate it if these records could be transferred by [Date].

Attached is my signed authorization form permitting the release of these records. If there are any fees associated with this request, or if you require additional information, please contact me at [Your Phone Number].

Thank you for your prompt assistance.

Sincerely,

[Your Signature]
[Your Printed Name]