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

[Date]

To: [Current Healthcare Provider/Clinic Name]
[Current Provider Address]

RE: Request for Direct Transfer of Clinical Records

To whom it may concern,

I am writing to formally request the transfer of my clinical records to a specialist provider. Please transfer my complete medical history, including but not limited to diagnostic reports, lab results, imaging, and treatment notes, to the provider listed below:

Receiving Specialist Information:
Name: [Specialist Name]
Clinic Name: [Specialist Clinic/Facility Name]
Address: [Specialist Address]
Phone: [Specialist Phone Number]
Fax/Email: [Specialist Fax or Secure Email]

I authorize the release of these records for the purpose of continuing my medical care. Please let me know if there are any specific forms required to finalize this request or if there are any associated processing fees.

Thank you for your prompt assistance in this matter.

Sincerely,

[Signature]

[Printed Name]