Subject: Request for Electronic Medical Record Transfer - [Patient Full Name]

[Date]

To: [Current Primary Physician or Clinic Name]
Address: [Clinic Street Address]
City, State, Zip: [City, State, Zip Code]
Phone: [Phone Number]

Re: Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/Account Number (if known): [ID Number]

To the Records Department,

I am writing to formally request the electronic forwarding of my medical records to the specialist listed below for the purpose of continued care.

Please transmit my records to:

Specialist Name: [Name of Specialist]
Facility Name: [Name of Practice/Hospital]
Email/Digital Portal: [Email Address or Direct Exchange Address]
Fax (if backup needed): [Fax Number]

Please include the following records from the period of [Start Date] to [End Date]:

- Progress notes and clinical summaries
- Laboratory and pathology reports
- Radiology/Imaging reports and digital files
- Immunization records
- Current medication list

I understand that these records may contain sensitive information. This authorization is valid for 90 days from the date of this letter.

Please notify me once the electronic transfer has been completed. If there are any fees associated with this request or if additional authorization forms are required, please contact me at [Your Phone Number] or [Your Email Address].

Thank you for your prompt assistance with this matter.

Sincerely,

[Signature]

[Printed Name]
[Phone Number]