Date: [Date]

To: [Name of Doctor or Facility Holding Records]
Address: [Street Address]
City, State, Zip: [City, State, Zip Code]

RE: Medical Records Release Request for Ongoing Treatment

Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Patient SSN (Optional): [Social Security Number]

Dear Medical Records Department,

I am writing to formally request a copy of my medical records to be transferred to my current healthcare provider for the purpose of ongoing treatment and continuity of care.

Please release the following information: [Check all that apply]
- Complete Medical Record
- Progress Notes
- Lab Reports and Imaging Results
- Medication Lists
- Treatment Plans

Date range of records requested: [Start Date] to [End Date/Present]

Please send these records directly to the following provider:

Receiving Provider Name: [New Doctor Name]
Facility Name: [New Clinic/Hospital Name]
Address: [Street Address]
Phone: [Phone Number]
Fax: [Fax Number]

I authorize the release of my medical records for the purpose stated above. This authorization is valid for 90 days from the date of signature unless revoked by me in writing.

Please contact me at [Your Phone Number] if there are any forms I need to sign or fees associated with this request.

Thank you for your prompt assistance in this matter.

Sincerely,

_____
[Patient Signature or Legal Representative]

[Printed Name]