Medical Record Transfer Request

Date: **[Insert Date]**

[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Medical Facility's Name]
[Facility's Address]
[City, State, Zip Code]

Dear [Medical Records Department/Name of Recipient],

I am writing to request the transfer of my medical records due to a recent change of address. My new address is as follows:

[New Address]
[City, State, Zip Code]

Please find my identification details below:

- Full Name: [Your Full Name]
- Date of Birth: [Your Date of Birth]
- Patient ID (if applicable): [Your Patient ID]

I would appreciate it if you could send my medical records to my new address or to my new healthcare provider at the following address:

[New Healthcare Provider's Name]
[Provider's Address]
[City, State, Zip Code]

Please let me know if you require any further information or forms to process this request. Thank you for your attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]
[Your Printed Name]