Medical Record Transfer Request

Date: [Insert Date]

From:

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

To:

[Receiving Healthcare Provider's Name]
[Clinic/Practice Name]
[Address]
[City, State, Zip Code]

Dear [Receiving Healthcare Provider's Name],

I am writing to request the transfer of my medical records for continuity of care. My details are as follows:

Patient Name: [Your Full Name]
Date of Birth: [Your Date of Birth]
Medical Record Number: [Your MRN, if applicable]

Please transfer all relevant medical records, including but not limited to my medical history, medications, allergies, and treatment plans.

I appreciate your assistance in this matter, as it is crucial for my ongoing healthcare needs. If you require any further information or documentation, please do not hesitate to contact me.

Thank you for your attention to this request.

Sincerely,

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