Medical Record Transfer Request

Date: [Insert Date]

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

[Recipient's Name]
[Recipient's Practice/Institution Name]
[Recipient's Address]
[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request the transfer of medical records for my family member, [Family Member's Name], born on [DOB of Family Member]. The records I wish to have transferred include all relevant medical history, treatment records, and any other pertinent health information.

We are requesting these records be sent to the following address:

[New Physician's Name/Practice]
[New Physician's Address]
[City, State, Zip Code]

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

Sincerely,

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