Medical Record Transfer Request

Date: [Insert Date]

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

[Recipient Name]
[Recipient Title/Position]
[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]

Dear [Recipient Name],

I am writing to request the transfer of my medical records to your office for the purpose of insurance verification.

Patient Name: [Your Name]
Patient Date of Birth: [Your Date of Birth]
Policy Number: [Your Policy Number]

Please send my medical records to the following address:

[Your Name]
[Your Address]
[City, State, Zip Code]

If you require any further information or authorization to process this request, please do not hesitate to contact me at the above phone number or email address.

Thank you for your assistance.

Sincerely,

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