Medical Record Transfer Request

Date: [Insert Date]

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

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

Dear [New Healthcare Provider's Name],

I am writing to request the transfer of my medical records from my previous healthcare provider, [Previous Provider's Name], to your practice. Below are my details:

- **Full Name:** [Your Full Name]
- **Date of Birth:** [Your Date of Birth]
- **Social Security Number:** [Your SSN (optional)]

My previous healthcare provider can be reached at:

- **Name:** [Previous Provider's Name]
- **Address:** [Previous Provider's Address]
- **Phone Number:** [Previous Provider's Phone Number]
- **Email:** [Previous Provider's Email (if available)]

Thank you for your attention to this matter. Feel free to contact me if you need any additional information.

Sincerely,
[Your Name]