Medical Record Transfer Request

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, ZIP Code]

[Your Email Address]

[Your Phone Number]

[Recipient's Name]

[Recipient's Title]

[Health Care Facility Name]

[Facility Address]

[City, State, ZIP Code]

Dear [Recipient's Name],

I am writing to formally request the transfer of my medical records for personal use. My details are as follows:

Name: [Your Full Name]

Date of Birth: [Your Date of Birth]

Patient ID (if applicable): [Your Patient ID]

Please send my medical records to my address listed above or provide me with a secure way to receive them. I appreciate your prompt attention to this matter and look forward to your response.

Thank you for your assistance.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]