

Health Records Transfer Form

To: [Recipient Name]

Address: [Recipient Address]

Date: [Date]

Dear [Recipient Name],

I am writing to request the transfer of my health records from your facility to my new healthcare provider. Below are my details:

Patient Name: [Your Name]

Date of Birth: [Your DOB]

Previous Provider: [Previous Provider Name]

New Provider: [New Provider Name]

New Provider Address: [New Provider Address]

Please include all relevant medical records including, but not limited to, physical exams, lab results, and treatment history.

Thank you for your assistance in this matter. If you have any questions or require further information, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].

Sincerely,

[Your Name]

[Your Signature (if sending a hard copy)]