Request for Transfer of Patient Records

Date: [Insert Date]

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

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

Dear [Healthcare Provider's Name],

I am writing to formally request the transfer of my medical records to [New Healthcare Provider's Name/Facility]. Please find my details below:

Patient Name: [Your Full Name]
Date of Birth: [Your DOB]
Patient ID/Record Number: [Your Patient ID]

I would appreciate it if you could send my medical records, including all relevant information regarding my medical history, treatments, and any other relevant documents to:

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

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

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