

Request for Medical Document Transfer

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Recipient's Name]

[Recipient's Title]

[Recipient's Institution/Practice]

[Institution/Practice Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I hope this message finds you well. I am writing to formally request the transfer of my medical documents from your facility to my new healthcare provider.

My details are as follows:

- Patient Name: [Your Full Name]
- Date of Birth: [Your Date of Birth]
- Medical Record Number: [Your Medical Record Number]

Please send my medical records to the following address:

[New Provider's Name]

[New Provider's Address]

[City, State, Zip Code]

If you require any further information or forms, please let me know. I appreciate your attention to this matter and look forward to your prompt response.

Thank you for your assistance.

Sincerely,

[Your Name]