Request for Patient Medical History Transfer

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

[Date]

[Recipient's Name]
[Recipient's Title]
[Medical Facility's Name]
[Facility's 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 history from [Current Medical Facility Name] to my new healthcare provider.

Patient Information:
Name: [Your Full Name]
Date of Birth: [Your Date of Birth]
Medical Record Number: [Your Medical Record Number if available]

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

Please send all relevant medical records including diagnostic reports, treatment history, and any other pertinent documents. I appreciate your prompt attention to this matter.

Thank you for your assistance.

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