Request for Medical Record Transfer

Date: [Insert Date]

[Recipient's Name]

[Recipient's Title]

[Hospital/Clinic Name]

[Hospital/Clinic Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to request the transfer of medical records for my family member, [Family Member's Name], who was treated at your facility. The details are as follows:

- **Patient Name:** [Family Member's Name]
- **Date of Birth:** [Family Member's DOB]
- **Medical Record Number:** [Medical Record Number]

Please send the medical records to the following address:

[Your Name]

[Your Address]

[City, State, Zip Code]

If you require any additional information or documentation, 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 Name]

[Your Relationship to Family Member]