Patient Request for Medical Record Transfer

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Recipient's Name]

[Facility Name]

[Facility Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to request the transfer of my medical records from your facility to my new healthcare provider.

My details are as follows:

- **Full Name:** [Your Full Name]
- **Date of Birth:** [Your Date of Birth]
- **Patient ID Number:** [Your Patient ID if applicable]

The new healthcare provider's information is:

- **Provider's Name:** [Provider's Name]
- **Facility Name:** [Facility Name]
- **Address:** [Facility Address]
- **Phone Number:** [Facility Phone Number]

Please let me know if you require any further information or if there are forms that I need to complete in order to facilitate this request. I appreciate your assistance in processing this transfer.

Thank you for your attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]