

Provider Request for Medical Record Transfer

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

[Recipient's Name]
[Recipient's Title]
[Recipient's Organization]
[Recipient's Address]
[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request the transfer of medical records for my patient, [Patient's Full Name], born on [Patient's Date of Birth], who was previously treated at your facility.

The specific records being requested include:

- All outpatient and inpatient records
- Medication history
- Lab results
- Radiology reports
- Any other relevant medical information

These records are necessary for continuity of care as the patient has recently transferred to my practice. Please send the requested medical records to my office at the address listed above or via secure email to [Your Email Address].

Thank you for your prompt attention to this matter. Please feel free to contact me at [Your Phone Number] if you have any questions or require further information.

Sincerely,

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