Request for Transfer of Medical Records

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]

To Whom It May Concern,

I am writing to formally request the transfer of my medical records from [Current Medical Provider's Name] located at [Current Provider's Address] to [New Medical Provider's Name] at [New Provider's Address].

My details are as follows:

- Full Name: [Your Full Name]
- Date of Birth: [Your DOB]
- Patient ID (if applicable): [Your Patient ID]

I would appreciate your prompt attention to this matter and would like to receive confirmation once the transfer has been initiated. If you require any further information to process this request, please do not hesitate to contact me at the number or email provided above.

Thank you for your assistance.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]