Health Data Transfer Request

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email]

[Your Phone Number]

[Recipient Name]

[Recipient Organization]

[Organization Address]

[City, State, Zip Code]

Dear [Recipient Name],

I am writing to formally request the transfer of my health data as per the Health Insurance Portability and Accountability Act (HIPAA) regulations. I would like to obtain a copy of my health records maintained by your organization.

Details of my health information are as follows:

- **Name:** [Your Full Name]
- **Date of Birth:** [Your Date of Birth]
- **Medical Record Number:** [Your MRN]

For your convenience, I have included a signed consent form that allows for the release of my information. I request that you send my health data to the following address:

[Your Preferred Address for Data Transfer]

Thank you for your prompt attention to this request. Please feel free to contact me at [Your Phone Number] or [Your Email] should you need any additional information.

Sincerely,

[Your Name]