# Family Physician Transfer Request

**Date:** [Insert Date]

**From:**

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]

**To:**

[New Physician's Name]

[New Physician's Practice Name]

[New Physician's Address]

[City, State, Zip Code]

Dear [New Physician's Name],

I am writing to formally request the transfer of my medical records from my current family physician, Dr. [Current Physician's Name], to your care. I have made the decision to change my primary care provider, and I believe that your practice will better suit my health care needs.

Please find my consent for the release of my medical records attached. Should you require any additional information or documentation to facilitate this transfer, do not hesitate to contact me.

Thank you for your attention to this request. I look forward to establishing care with you.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]