Medical Records Request for Continuity of Care

Date: [Insert Date]

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

[Recipient's Name]
[Recipient's Title/Position]
[Medical Facility/Practice Name]
[Facility Address]
[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request my medical records to ensure continuity of care. As I transition to new healthcare providers, it is essential for me to have access to my complete medical history.

Please include the following information in the records:

- Medical history
- Medications
- Lab results
- Immunization records
- Any other relevant information

I understand that my medical records are protected; therefore, I authorize the release of my records to be sent to the following address:

[Your New Healthcare Provider's Name]
[Provider's Address]
[City, State, Zip Code]

Please let me know if there are any forms or additional information required to process this request.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

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