Medical History Request for Continuity of Care

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

[Date]

[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 request a copy of my medical history in order to ensure continuity of care as I transition to new healthcare providers. My medical records are vital for my ongoing treatment and health management.

Please include all relevant information concerning my diagnoses, treatment plans, medications, and any other pertinent medical information. For your reference, my details are as follows:

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

Thank you for your attention to this matter. I appreciate your prompt assistance in providing my medical records.

Sincerely,

[Your Name]