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

[Date]

[Medical Provider Name]
[Facility Name]
[Department, e.g., Medical Records Department]
[Address]
[City, State, Zip Code]

RE: Request for Medical Records

To Whom It May Concern,

I am writing to formally request a copy of my medical records for the period of [Start Date] to [End Date].

Patient Information:
Name: [Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/Account Number (if known): [Number]

Please provide the following specific records:
[List specific records, e.g., Discharge summaries, Lab results, Imaging reports, Progress notes]

I would prefer to receive these records in [Electronic/Paper] format. If there is a fee for the duplication of these records, please notify me of the cost before processing the request.

I have attached a signed authorization form as required by HIPAA regulations. If you require any further information or a specific form from your office, please let me know immediately.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]