

[Your Name]
[Your Address]
[Your Phone Number]
[Your Email]

[Date]

[Recipient Name]
[Recipient Title/Department]
[Organization Name]
[Organization Address]

RE: Supporting Medical Records for [Patient Name] (DOB: [Date of Birth])

To Whom It May Concern,

Please find enclosed the supporting medical records regarding [Patient Name] for your review. These documents are being submitted in relation to [Reference Number, Claim Number, or Purpose of Submission].

The enclosed records include:

- [Document Name 1 - e.g., Diagnostic Reports]
- [Document Name 2 - e.g., Physician Evaluation Notes]
- [Document Name 3 - e.g., Hospital Discharge Summary]
- [Document Name 4 - e.g., Lab Results]

These records provide necessary documentation for [Reason for submission, e.g., an ongoing insurance claim, disability application, or continuity of care].

If you require any additional information or have questions regarding these documents, please contact me directly at [Your Phone Number].

Sincerely,

[Your Signature]

[Your Printed Name]

Enclosures: [Total Number] pages of medical documentation