

**[Clinic or Hospital Name]**

[Address Line 1]

[Address Line 2]

[Phone Number]

**Date:** [Date]

**RE: Clinical Assessment and Condition Verification**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Patient DOB]

**Patient ID/MRN:** [ID Number]

To Whom It May Concern,

I am writing to formally verify the clinical status of the above-named patient. [Patient Name] is currently under my medical care at [Clinic Name].

Following a comprehensive clinical assessment conducted on [Date of Last Evaluation], I am confirming the diagnosis of the following chronic condition(s):

- [Condition Name 1] (ICD-10 Code: [Code])
- [Condition Name 2] (ICD-10 Code: [Code])

**Clinical Summary:**

The patient has been diagnosed with these conditions since [Year or Date]. These conditions are considered chronic in nature, requiring ongoing medical management, monitoring, and [mention specific requirements like medication, therapy, or specialized equipment].

**Functional Impact:**

Due to these chronic conditions, the patient experiences the following limitations: [List brief functional limitations if applicable].

I certify that the information provided above is true and accurate based on the patient's current medical records and clinical evaluations.

Should you require further documentation or have any questions regarding this assessment, please contact my office at [Phone Number].

Sincerely,

[Doctor's Signature]

**[Doctor's Full Name, Degree]**

[Medical License Number]

[Board Certification]