

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

[Date]

Social Security Administration
[Local Office Address]
[City, State, Zip Code]

RE: Social Security Disability Insurance Support for [Patient Full Name]
Date of Birth: [Patient DOB]
SSN: [Patient SSN]

To Whom It May Concern:

I am writing this letter in my official capacity as the Clinic Administrator at [Clinic Name] to verify the medical status and treatment history of [Patient Name]. Our records confirm that the patient has been under the care of our facility since [Start Date] and is currently treated by [Treating Physician's Name].

The patient has been diagnosed with the following medically determinable impairments:
- [Diagnosis 1]
- [Diagnosis 2]

Based on our clinical documentation and the assessments provided by our medical staff, these conditions significantly limit the patient's ability to perform basic work-related activities. Specifically, the patient suffers from [mention key limitations, e.g., chronic pain, cognitive deficits, reduced mobility] which prevent them from maintaining gainful employment.

The patient is currently prescribed the following treatment plan:
- [List medications/therapies]
- [Frequency of visits]

Despite compliance with this treatment regimen, the patient's prognosis remains [stable/guarded/declining]. It is the opinion of our clinical team that these limitations have lasted, or are expected to last, for a continuous period of at least 12 months.

Attached are the relevant medical records, diagnostic test results, and physician notes to support this claim. Please contact our office at [Phone Number] should you require further documentation or clarification.

Sincerely,

[Signature]

[Printed Name]
Clinic Administrator
[Clinic Name]