[Your Name/Department Name]
[Facility Name]
[Street Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Medical Records Release for Disability Determination
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Social Security Number: [Patient SSN]

To the Disability Determination Services Evaluator:

This letter is to formally transmit the requested medical records for the above-named patient in support of their application for Social Security Disability Insurance (SSDI) benefits.

The enclosed records cover the period from [Start Date] to [End Date] and include:

- Diagnostic test results and imaging reports
- Clinical progress notes and physical examination findings
- History of treatments, medications, and responses
- Hospitalization records and surgical summaries

These records document the patient's diagnosed conditions, specifically: [List Primary Diagnoses]. They provide objective evidence regarding the patient's functional limitations and the severity of their impairments as they relate to their ability to perform work-related activities.

Should you require further clarification or additional documentation regarding these records, please contact our Medical Records Department at [Phone Number] or via fax at [Fax Number].

Respectfully,

[Signature]

[Printed Name]
[Title/Credential]
[Department Name]