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

RE: Disability Verification for [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Patient ID: [ID Number]

To Whom It May Concern:

I am writing this letter in my capacity as the Medical Director of [Clinic Name] to formally verify the disability status of [Patient Name]. Our clinical records confirm that the patient has been under the care of this facility since [Start Date].

The patient has been diagnosed with the following permanent or long-term medical condition(s):
[List Diagnoses/Condition Codes]

Based on our clinical evaluations and medical history, these conditions result in significant functional limitations in the following areas:
[List Functional Limitations, e.g., mobility, cognitive processing, lifting, etc.]

As a result of these impairments, it is our medical opinion that [Patient Name] meets the criteria for being considered a person with a permanent disability. These limitations are expected to last [Duration/Indefinitely] and substantially limit one or more major life activities.

Please feel free to contact our office at [Phone Number] should you require further documentation or clinical clarification regarding this patient's status.

Sincerely,

[Signature]
[Name of Medical Director, Degree]
Medical Director
[Medical License Number]
[Clinic Stamp/Seal]