

Date: [Insert Date]

To: [Medical Clinic Name]

Attention: Medical Records Department

Address: [Clinic Street Address]

City, State, Zip: [City, State, Zip Code]

RE: Medical Records Request for Total and Permanent Disability (TPD) Discharge

Patient Name: [Your Full Name]

Date of Birth: [Your Date of Birth]

Patient SSN (Last 4 digits): [Last 4 Digits of SSN]

Phone Number: [Your Phone Number]

To Whom It May Concern,

I am writing to formally request a copy of my medical records for the purpose of applying for a Total and Permanent Disability (TPD) discharge of my federal student loans. Under the U.S. Department of Education requirements, I must provide medical evidence of a physical or mental impairment that prevents me from engaging in substantial gainful activity.

Please provide the following records from [Start Date] to [End Date/Present]:

- Office visit summaries and clinical notes
- Diagnostic test results and imaging reports
- List of current and past medications
- Treating physician's assessments regarding my functional limitations

If your office requires a specific HIPAA authorization form to be signed, please send it to me immediately or let me know where I can find it online. Please also inform me of any reasonable fees associated with this request so that I may provide payment.

Please send the requested documents to:

[Your Name]

[Your Mailing Address]

[Your City, State, Zip Code]

Thank you for your prompt assistance with this matter.

Sincerely,

[Your Printed Name]