

Date: [Insert Date]

TO: [Recipient Name/Organization]

FROM: [Healthcare Provider/Clinic Name]

SUBJECT: Patient Identification and Verification

To Whom It May Concern,

This letter serves to confirm the identity and registration of the following patient currently under our care:

- **Full Legal Name:** [First Name] [Last Name]
- **Date of Birth:** [MM/DD/YYYY]
- **Patient ID/Medical Record Number:** [Insert ID Number]
- **Current Address:** [Street Address, City, State, Zip Code]
- **Gender:** [Male/Female/Other]

The identity of the patient was verified using the following government-issued documentation: [e.g., Driver's License, Passport, State ID].

If you require further verification or have any questions regarding this information, please contact our office at [Phone Number] or via email at [Email Address].

Sincerely,

[Signature]

[Printed Name]

[Title/Position]

[Facility Name]