[Your Full Name]
[Date of Birth]
[Social Security Number or Patient ID]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[Physician Name or Medical Records Department]
[Facility Name]
[Facility Address]
[City, State, Zip Code]

RE: Request for Comprehensive Medical Records

To Whom It May Concern,

I am writing to formally request a complete and comprehensive copy of my medical records maintained by your facility. This request includes, but is not limited to, the following information for the period of [Start Date] to [End Date/Present]:

- Office visit notes and clinical summaries
- Diagnostic test results (Laboratory work, X-rays, MRIs, CT scans)
- Surgical and procedure reports
- Immunization records
- Current and past medication lists
- Prescriptions and treatment plans
- Allergy information
- Consultation reports from other providers

Please provide these records in [Electronic Format / Physical Paper Copy]. If there is a fee associated with the duplication and delivery of these records, please notify me in advance of the total cost.

I am requesting these records for [Personal Records / Referral to a Specialist / Insurance Purposes]. Under HIPAA regulations, I understand that these records should be provided within 30 days.

Thank you for your prompt attention to this matter.

Sincerely,

[Signature for Printed Letter]
[Your Printed Name]