

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Re: Verification of Patient Identity - [Patient Account Number/DOB]

Dear [Patient Name],

We are contacting you following our previous request regarding the verification of your identity. As part of our commitment to patient safety and the security of your protected health information, we require updated identification on file.

To complete your registration and ensure there are no delays in your future care or billing processes, please provide a copy of one of the following documents:

- A valid state-issued driver's license
- A valid government-issued photo ID
- A valid passport

You may submit this information by:

- Bringing the original document to our front desk during office hours.
- Uploading a secure copy via the Patient Portal at [URL].
- Faxing a copy to [Fax Number], Attention: Medical Records.

If we do not receive this verification by [Date], we may be unable to process certain requests or updates to your file. If you have already provided this information, please disregard this notice.

Should you have any questions, please contact our office at [Phone Number].

Sincerely,

[Your Name/Department Name]

[Healthcare Facility Name]