

[Current Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Subject: ACTION REQUIRED - Unsigned Medical Records Release Form

Dear [Patient Name],

We are writing to follow up on your request to transfer or release your medical records. Upon reviewing your documentation, we noticed that the **Medical Records Release Authorization** form was returned without a signature.

For your protection and to comply with HIPAA privacy regulations, we cannot process your request or release any health information until we have a valid signature on file.

To complete this process, please:

- Sign and date the attached Authorization Form.
- Return the signed form to our office via mail, fax at [Fax Number], or in person.

If you have already sent a signed copy, please disregard this notice. If you have any questions regarding this requirement, please contact our Medical Records Department at [Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name/Department]

[Facility Name]

[Phone Number]