Date: [Insert Date]

To: [Name of Facility/Doctor]
Department: [e.g., Medical Records Department]
Address: [Insert Address]
City, State, Zip: [Insert City, State, Zip]

RE: Medical Record Request for [Patient Full Name]

Patient Information:
Date of Birth: [Insert DOB]
Social Security Number (Optional/Last 4): [Insert SSN]
Phone Number: [Insert Phone Number]

To Whom It May Concern,

I am writing to formally request a copy of my medical records. Please provide the following documentation:

- [ ] Complete medical record (all dates)
- [ ] Records for the following date range: [Insert Dates]
- [ ] Specific records: [e.g., Lab results, Imaging reports, Progress notes]
- [ ] Billing statements

Please deliver these records in the following format:

- [ ] Electronic format (CD, USB, or Secure Email: [Insert Email])
- [ ] Paper copies via mail to: [Insert Mailing Address]

I understand that there may be a reasonable fee associated with the duplication of these records. Please notify me in advance if the cost exceeds $[Insert Amount].

If you have any questions regarding this request, please contact me at [Insert Phone Number]. Thank you for your prompt attention to this matter.

Sincerely,

_____
[Patient or Authorized Representative Signature]

[Printed Name]