[Your Name]
[Your Date of Birth]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

[Doctor or Clinic Name]
[Department, if applicable]
[Facility Address]
[City, State, Zip Code]

RE: Request for Complete Medical Records

To the Medical Records Department,

I am writing to formally request a complete copy of my medical records. Please provide all information regarding my care at your facility from [Start Date] to [End Date/Present].

Specifically, I am requesting the following:

- Physician notes and consultation reports
- Lab results and pathology reports
- Imaging reports (X-rays, MRIs, CT scans)
- Immunization records
- List of prescribed medications and dosages
- Discharge summaries and surgical reports

Please provide these records in [Electronic/Paper] format. If there is a fee associated with the duplication or delivery of these records, please notify me of the cost before processing the request.

I have attached a signed authorization form to this letter to confirm my identity and consent for the release of these records.

Thank you for your assistance. I look forward to receiving these documents within [Number] business days as per state/federal guidelines.

Sincerely,

[Signature]
[Printed Name]