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

[Date]

[Name of Doctor or Hospital]
[Department, if known]
[Address of Facility]

RE: Request for Specific Medical Records

To the Medical Records Department,

I am writing to formally request a copy of my medical records regarding a specific treatment I received at your facility.

Please provide the following specific records:
Type of Treatment/Procedure: [Enter Treatment Name, e.g., Knee Surgery]
Date(s) of Treatment: [Enter Date or Date Range]
Specific Documents Requested: [e.g., Operative reports, lab results, discharge summary, or imaging films]

I would prefer to receive these records in [digital format via email / paper format via mail].

If there is a fee associated with the duplication of these records, please notify me in advance. If you require a specific HIPAA authorization form to be signed, please send it to me immediately so I may complete it.

Thank you for your prompt attention to this request as per my rights under HIPAA regulations.

Sincerely,

[Your Signature]

[Your Printed Name]