[Your Name]
[Your Law Firm/Organization]
[Street Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Custodian of Records]
[Facility Name]
[Department Name]
[Street Address]
[City, State, Zip Code]

RE: REQUEST FOR MEDICAL RECORDS
Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Social Security Number: [Last 4 Digits or Full SSN]
Dates of Service: [Start Date] to [End Date]

To Whom It May Concern,

This office represents [Client Name] in connection with a legal proceeding. Please provide a complete and certified copy of all medical records pertaining to the above-named patient for the specified dates of service.

This request includes, but is not limited to:

- Physician notes and clinical summaries
- Diagnostic test results (Labs, X-rays, MRI, CT scans)
- Emergency room and admission records
- Surgical and operative reports
- Medication and pharmacy logs
- Billing and insurance statements

Attached please find a signed HIPAA-compliant authorization form executed by the patient, permitting the release of these records to our office.

If there is a fee for the reproduction of these records, please notify us in advance or include the invoice with the records. If you do not possess the records requested, please inform us immediately.

Please deliver the records via [Electronic Delivery/Certified Mail] to the address listed above.

Thank you for your prompt attention to this matter.

Sincerely,

[Signature]
[Your Printed Name]
[Title]

Enclosure: HIPAA Authorization Form