[Your Name]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

[Hospital or Clinic Name]
[Billing/Medical Records Department]
[Address]

RE: Request for Itemized Billing and Medical Records

Patient Name: [Full Name of Patient]
Date of Birth: [MM/DD/YYYY]
Account/Patient Number: [Account Number]
Date(s) of Service: [Date range of treatment]

To Whom It May Concern,

I am writing to formally request a complete itemized bill and copies of my medical records for the dates of service listed above.

Regarding the billing, please provide an itemized statement that includes the following for each charge:

- Date of service
- HCPCS/CPT codes
- Description of services or supplies
- The specific cost for each item before any discounts or insurance adjustments

Regarding the medical records, please provide copies of:

- Discharge summary
- Physician's notes and orders
- Laboratory and diagnostic test results
- Operative reports (if applicable)

I am requesting these documents for the purpose of personal record-keeping and insurance verification. Please notify me in advance if there are any fees associated with processing this request.

I have enclosed a signed HIPAA authorization form for the release of these records. Please send the requested documents to my address listed above within [Number, e.g., 30] days as per state and federal guidelines.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]