**URGENT: TIME-SENSITIVE MEDICAL RECORDS REQUEST**

Date: [Insert Date]

To: [Custodian of Records/Facility Name]
Address: [Insert Facility Address]
Phone/Fax: [Insert Facility Contact Info]

**RE: Patient Information**
Patient Name: [Insert Full Name]
Date of Birth: [Insert DOB]
Social Security Number: [Insert Last 4 Digits - Optional]
Dates of Service: [Insert Specific Dates or "All Records"]

To Whom It May Concern,

This is a formal request for the immediate release of the medical records for the above-named patient. These records are required for **urgent medical necessity/legal deadlines**. Please provide the following documents:

- Discharge Summary
- Imaging Reports (X-ray, MRI, CT)
- Lab Results and Pathology Reports
- Operative Reports
- Physician Progress Notes

Please deliver these records via [Secure Email/Fax/Mail] no later than [Insert Deadline Date].

Attached is the signed HIPAA-compliant Authorization for Release of Information. If there are any fees associated with this request, please notify me immediately so that payment can be expedited.

If you cannot fulfill this request within the specified timeframe, please contact me immediately at [Insert Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Relationship to Patient]
[Your Phone Number/Email]