

## **URGENT: PRIORITY HEALTH RECORDS REQUEST**

**Date:** [Insert Date]

**To:** [Medical Records Department/Provider Name]

**Facility:** [Name of Outpatient Clinic/Facility]

**Fax/Email:** [Insert Fax Number or Email Address]

### **RE: Patient Health Records Request**

**Patient Name:** [Insert Full Name]

**Date of Birth:** [Insert Date of Birth]

**Patient ID/SSN:** [Insert ID Number if applicable]

To Whom It May Concern,

This is a formal request for the **expedited** release of medical records for the above-named patient. These records are required for urgent follow-up outpatient care scheduled on **[Insert Appointment Date]**.

Please provide the following records from **[Insert Start Date]** to **[Insert End Date]**:

- Office visit notes and consultation reports
- Diagnostic imaging reports (MRI, CT, X-ray)
- Laboratory and pathology results
- Current medication list and immunization records
- Discharge summaries (if applicable)

Please deliver these records via the following method:

Fax to: [Insert Fax Number]

Secure Email to: [Insert Email Address]

Patient Pickup

Attached is the signed Authorization for Release of Information. Under HIPAA regulations and applicable state law, please process this priority request as quickly as possible to ensure continuity of care.

If there are any fees associated with this request, or if you require further information, please contact our office immediately at [Insert Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Relationship to Patient/Title]