Date: [Date]
To: [Imaging Center/Hospital Name]
Department: Medical Records / Radiology Department
Fax/Email: [Recipient Fax/Email]

RE: REQUEST FOR DIAGNOSTIC ULTRASOUND RESULTS

Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Patient ID/SSN: [Optional ID Number]
Date of Service: [Date Ultrasound was Performed]

To Whom It May Concern,

I am writing to formally request the diagnostic imaging results for the above-named patient. Our records indicate that an ultrasound was performed at your facility on the date specified above.

Please provide the following documentation for our clinical review:

- Official Radiologist Interpretation Report
- Diagnostic Images (via secure link, CD, or film if available)

Please transmit these records via one of the following methods:

- **Fax:** [Your Fax Number]
- **Secure Email:** [Your Secure Email]
- **Patient Portal:** [Provider Portal Name/Link]

If there are any issues locating these records or if a signed authorization is required beyond the standard HIPAA-compliant treatment disclosure, please contact our office immediately at [Your Phone Number].

Thank you for your prompt assistance in ensuring the continuity of care for this patient.

Sincerely,

[Physician Signature]
[Physician Name, Degree]
[Practice/Clinic Name]
[NPI Number]