

[Your Full Name]  
[Your Date of Birth]  
[Your Address]  
[Your Phone Number]  
[Your Email Address]

[Date]

[Name of Provider or Facility]  
[Department, e.g., Records Department]  
[Address of Facility]

**RE: Request for Mental Health Medical Records**

To Whom It May Concern,

I am writing to formally request a copy of my mental health records maintained by your facility. This request is made in accordance with my rights under HIPAA and applicable state laws.

**Patient Information:**

Name: [Your Full Name]  
Date of Birth: [MM/DD/YYYY]  
Patient ID/Account Number (if known): [Number]

**Records Requested:**

I am requesting access to the following information for the period of [Start Date] to [End Date]:

- Intake and discharge summaries
- Diagnostic assessments
- Treatment plans
- Progress notes
- Medication records
- Laboratory results

**Format and Delivery:**

I would prefer to receive these records in [digital/paper] format. Please [mail them to the address above / email them to the address above].

If there is a fee for copying or mailing these records, please notify me of the total cost before processing this request. If you are unable to fulfill any part of this request, please provide a written explanation for the denial and information on how I may appeal the decision.

Thank you for your assistance with this matter. I look forward to receiving these records within the legally required timeframe.

Sincerely,

[Your Signature]

[Your Printed Name]