[Law Firm Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Medical Provider Name]
[Records Department]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]

**RE: Request for Medical Records**
**Patient Name:** [Patient Full Name]
**Date of Birth:** [Patient Date of Birth]
**Social Security Number:** [Last 4 Digits]
**Date of Incident/Service:** [Date Range]

To Whom It May Concern,

This office represents the above-named individual in a legal matter. We request a complete copy of any and all medical records pertaining to our client for the period of [Start Date] to [End Date].

Please provide the following documentation:

- Complete medical chart and clinical notes
- Diagnostic imaging reports (MRI, CT, X-ray)
- Laboratory and test results
- Itemized billing statements
- Pharmacy and medication records

Attached please find a signed HIPAA-compliant Authorization for Release of Health Information executed by our client.

If there is a fee for the reproduction of these records, please provide an invoice or contact our office if the cost exceeds [Dollar Amount]. Please forward the requested documents to our office address listed above or via secure email at [Email Address].

Thank you for your prompt attention to this request.

Sincerely,

[Signature]

[Attorney/Representative Name]
[Law Firm Name]

**Enclosure:** Signed Medical Authorization