DATE: [Date]

TO:
[Medical Provider Name]
[Medical Provider Address]
[City, State, Zip Code]

RE: NOTICE OF REPRESENTATION AND REQUEST FOR MEDICAL RECORDS

PATIENT NAME: [Patient Name]
DATE OF BIRTH: [Patient DOB]
SOCIAL SECURITY NUMBER: [Patient SSN (Optional)]
DATE OF INCIDENT: [Date of Incident]

To Whom It May Concern,

Please be advised that this office represents the above-named individual regarding injuries sustained in an incident on the date listed above.

Pursuant to HIPAA regulations and the enclosed signed authorization, we hereby request a complete copy of all medical records and itemized billing statements related to our client for the period of [Start Date] to [End Date/Present].

Requested documentation includes, but is not limited to:

- Admission and discharge summaries
- Emergency room records
- Physician and nursing notes
- Diagnostic test results (X-rays, MRIs, CT scans)
- Operative reports
- Itemized billing statements reflecting all charges, payments, and adjustments

If there is a fee for the reproduction of these records, please provide an invoice and we will remit payment promptly. Please deliver the records via [Email Address/Fax Number/Mailing Address].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name/Law Firm Name]
[Phone Number]
[Email Address]

Enclosure: Signed HIPAA Authorization