[Your Law Firm Name]
[Street Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Custodian of Records]
[Medical Facility Name]
[Street Address]
[City, State, Zip Code]

RE: REQUEST FOR COMPLETE MEDICAL RECORDS
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Social Security Number: [SSN - Optional/Last 4]
Date(s) of Service: [Insert Dates or "All Dates"]

To Whom It May Concern,

Please be advised that this office represents the above-named patient in a legal matter. Pursuant to all applicable state and federal laws, including HIPAA, we hereby request a complete copy of the patient's entire medical record file.

This request includes, but is not limited to, the following:

- All physician notes, clinical summaries, and consultation reports;
- Diagnostic imaging reports and actual films/CDs (X-rays, MRI, CT scans);
- Laboratory and pathology results;
- Emergency room records and admission/discharge summaries;
- Prescription and medication logs;
- Nursing and administrative notes;
- Itemized billing statements including all codes (ICD-10/CPT).

Attached is a signed Authorization for Release of Protected Health Information executed by our client. Please provide these records in electronic format (PDF via secure link or CD) if possible. If there is a fee for the reproduction of these records, please provide an invoice with the records or contact our office for payment.

If any portion of these records is withheld for any reason, please provide a written explanation for such redaction or omission. We request that these records be produced within [Number] days of receipt of this letter.

Thank you for your prompt attention to this matter.

Sincerely,

[Signature]
[Printed Name of Attorney]
[Law Firm Name]

Enclosure: Signed HIPAA Authorization Form