DATE: [Insert Date]

TO:
Custodian of Medical Records
[Name of Medical Facility/Provider]
[Address]
[City, State, Zip Code]

RE: Request for Certified Medical Records

PATIENT NAME: [Patient's Full Name]
DATE OF BIRTH: [Patient's Date of Birth]
SOCIAL SECURITY NUMBER: [Patient's SSN - Optional]
DATES OF SERVICE: [From Date] to [To Date]

Dear Custodian of Records,

This office represents [Client Name] in a legal matter regarding medical care received at your facility. Please find the enclosed HIPAA-compliant authorization form signed by our client, which permits the release of their protected health information to our firm.

We formally request a complete and certified copy of all medical records pertaining to the patient named above, including but not limited to:

- Admission and discharge summaries
- Physician orders and progress notes
- Nursing and clinical notes
- Laboratory, pathology, and diagnostic test results
- Imaging reports and actual films/CDs (X-rays, MRIs, CT scans)
- Operative and anesthesia reports
- Medication administration records (MAR)
- Billing and insurance statements

Please provide these records in electronic format (CD or secure digital transfer) if possible. If there is a fee for the duplication of these records, please provide an invoice or notify our office if the cost exceeds $[Insert Amount].

Pursuant to state and federal law, please fulfill this request within [Insert Number of Days] days. If you have any questions, please contact our office at [Your Phone Number].

Sincerely,

[Your Name/Signature]
[Law Firm Name]
[Address]

[Phone Number]
[Email Address]

ENCLOSURE: Signed Medical Privacy Authorization (HIPAA)