[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 EXPEDITED ELECTRONIC MEDICAL RECORDS

Patient Name: [Client Full Name]
Date of Birth: [DOB]
Social Security Number: [Last 4 Digits]
Date(s) of Service: [Date Range]

To Whom It May Concern,

This office represents [Client Name] regarding a legal matter. Attached to this request, please find a signed Authorization for Release of Information permitting us to obtain our client's medical records.

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) and 45 CFR $ 164.524, we formally request an **electronic copy** of the complete medical record for the patient listed above. Please provide the records in digital format (e.g., PDF) via secure email, download link, or encrypted CD/USB.

The requested records should include, but are not limited to:

- Admission and discharge summaries
- Progress notes and physician orders
- Diagnostic imaging reports (MRI, X-Ray, CT)
- Laboratory and pathology results
- Itemized billing statements

As these records are being requested in electronic format, we request that any applicable fees be limited to the "Patient Rate" for labor and supplies as allowed under federal law. Please notify us immediately if the costs will exceed $[Amount].

Please deliver the electronic files to: [Email Address or Secure Portal Link].

If you have any questions or if these records are maintained by a third-party vendor, please notify our office at [Phone Number]. Thank you for your prompt attention to this matter.

Sincerely,

[Attorney Name]
[Law Firm Name]

Enclosure: Signed Authorization for Release of Medical Information