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

[Date]

[Provider Name/Medical Facility]
[Medical Records Department]
[Street Address]
[City, State, Zip Code]

RE: REQUEST FOR MEDICAL RECORDS AND BILLING STATEMENTS

Patient Name: [Client Full Name]
Date of Birth: [DOB]
Social Security Number: [Last 4 Digits - Optional]
Date of Incident/Service: [Date Range]

To Whom It May Concern:

Please be advised that this office represents [Client Name] regarding injuries sustained on or about [Date of Incident].

We hereby request a complete copy of all medical records and itemized billing statements pertaining to the treatment of our client. This request includes, but is not limited to:

- Emergency room records
- Physician notes and progress reports
- Diagnostic test results (X-rays, MRI, CT scans, Lab reports)
- Consultation reports
- Discharge summaries
- Itemized billing statements showing all charges and payments

Attached please find a signed HIPAA-compliant authorization form executed by our client, permitting the release of these records to our office.

If there is a fee for the duplication of these records, please provide an invoice with the records or notify us of the cost in advance if it exceeds $[Amount]. Please forward the requested documents to our office address listed above.

Thank you for your prompt attention to this matter.

Sincerely,

[Attorney Signature]

[Attorney Name]
[Law Firm Name]

Enclosure: Signed Medical Authorization