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

[Date]

[Medical Provider Name]
[Medical Facility Address]
[City, State, Zip Code]

RE: REQUEST FOR MEDICAL RECORDS
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Social Security Number: [Last 4 Digits - Optional]
Dates of Service: [Start Date] to [End Date]

To the Records Department Administrator,

Please be advised that this office represents [Patient Full Name] regarding a legal matter. We are formally requesting a complete copy of the medical records for the above-referenced patient for the following dates of service: **[Start Date] through [End Date]**.

This request includes, but is not limited to:

- Physician notes and clinical summaries
- Diagnostic test results (X-rays, MRI, Labs)
- Emergency room records
- Prescription and medication logs
- Billing statements and itemized charges

Attached is a signed HIPAA-compliant authorization form executed by the patient, granting our firm permission to receive these records.

Please provide these records in electronic format (PDF) if possible. If there is a fee associated with this request, please provide an invoice or contact our office for payment processing.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Law Firm]

Enclosure: Signed HIPAA Authorization