[Date]

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

RE: Request for Medical Records
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
SSN: [Patient SSN (Optional)]
Date of Incident/Service: [Relevant Dates]

To the Records Custodian:

Please be advised that this office represents the above-named individual.

Enclosed please find a signed Authorization for Release of Protected Health Information. Pursuant to this authorization, we request a complete copy of any and all medical records, including but not limited to:

- Emergency room records
- Admission and discharge summaries
- Progress notes and physician orders
- Radiology reports and imaging (CD/Digital)
- Laboratory results
- Billing and itemized statements

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

Thank you for your prompt attention to this matter.

Sincerely,

[Signature]
[Printed Name]
[Law Firm/Title]
[Phone Number]
[Email Address]

Enclosure: Executed HIPAA Authorization