[Date]

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

RE: REQUEST FOR MEDICAL RECORDS

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Injury: [DOI]
Claim Number: [Claim Number]

To the Custodian of Records,

Please provide a complete copy of all medical records, reports, and billing statements pertaining to the treatment of the above-named patient regarding their work-related injury.

Specifically, we request the following:

- Initial evaluation reports
- Progress notes and clinical summaries
- Diagnostic test results (X-ray, MRI, EMG, etc.)
- Work status forms (Work restrictions/releases)
- Itemized billing statements

Attached is a signed medical authorization form executed by the patient. If there is a fee for the reproduction of these records, please notify our office before processing, or include the invoice with the records.

Please send the requested documents to:

[Your Name/Company Name]
[Your Address]
[Your Phone Number]
[Your Email Address]

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]