

[Date]

[Medical Provider Name]

[Clinic/Hospital Name]

[Address]

[City, State, Zip Code]

RE: Workers' Compensation Medical Record Request

Employee Name: [Employee Full Name]

Date of Birth: [DOB]

Date of Injury: [Date]

Claim Number: [Claim Number]

To Whom It May Concern,

Our company, [Company Name], is the employer of the above-named individual. This employee has filed a workers' compensation claim regarding an injury sustained on [Date of Injury].

Pursuant to state workers' compensation laws, we are requesting a complete copy of the medical records pertaining to the evaluation and treatment of the specific injury mentioned above. Please include the following:

- Diagnostic reports and test results
- Physician notes and summaries
- Work status reports (Form [Specific State Form Number if applicable])
- Treatment plans and referrals
- Itemized billing statements

Please send the requested documentation to the following address:

[Company Name]

Attn: [Name/Department]

[Mailing Address]

[City, State, Zip Code]

[Email/Fax Number]

Under workers' compensation statutes, an employer is entitled to medical information directly related to a workplace injury claim. If a signed authorization from the employee is required by your facility for processing, one has been attached to this request.

Thank you for your prompt assistance in this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title]
[Phone Number]