DATE: [Insert Date]

TO:
[Custodian of Records]
[Medical Facility Name]
[Address]
[City, State, Zip Code]

RE: MEDICAL RECORD REQUEST
Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]
Social Security Number: [Insert SSN]
Date of Injury: [Insert Date of Injury]
Claim Number: [Insert Claim Number]

Dear Custodian of Records,

This office represents the above-named individual regarding a Workers' Compensation claim. A signed authorization for the release of protected health information is enclosed.

Please provide complete and unredacted copies of all medical records in your possession pertaining to the patient, including but not limited to:

- Initial intake forms and history
- Progress notes and office visit reports
- Diagnostic imaging reports (X-ray, MRI, CT scans)
- Operative reports and discharge summaries
- Physical therapy and rehabilitation records
- Itemized billing statements

Please provide these records for the period of [Insert Start Date] to the present.

If there is a fee for these records, please provide an invoice with the production of the documents. If the cost exceeds $[Insert Dollar Amount], please contact our office for approval prior to processing.

Please forward the requested materials to:

[Law Firm Name]
[Attn: Attorney/Paralegal Name]
[Address]
[City, State, Zip Code]

Thank you for your prompt attention to this matter.

Sincerely,

[Attorney Signature]
[Printed Name]
[Law Firm Name]

Enclosure: Signed HIPAA Authorization