FINAL NOTICE

Date: [Insert Date]

To: [Custodian of Records/Facility Name]
Address: [Facility Address]
City, State, Zip: [City, State, Zip]

RE: Workers' Compensation Medical Record Request
Patient Name: [Patient Name]
Date of Birth: [Date of Birth]
Date of Injury: [Date of Injury]
Claim Number: [Claim Number]

To Whom It May Concern,

This letter serves as a **FINAL NOTICE** regarding our previous requests dated [First Request Date] and [Second Request Date] for the medical records of the above-referenced patient.

To date, we have not received the requested documentation. These records are essential for the adjudication of a Workers' Compensation claim. Failure to provide these records may result in a formal subpoena or the filing of a complaint with the appropriate state regulatory agency.

Please provide complete copies of the following records from [Start Date] to [End Date]:

- Office Visit Notes and Progress Reports
- Diagnostic Test Results (X-rays, MRI, CT, EMG)
- Operative Reports
- Physical Therapy Notes
- Billing Statements (HCFA/CMS-1500 forms)

Attached is a signed HIPAA-compliant authorization form. Please fax the records to [Fax Number] or mail them to the address listed below within [Number of Days] business days.

If the records have already been sent, please disregard this notice.

Sincerely,

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