Date: [Insert Date]

To: [Specialist Name or Facility Name]
Address: [Street Address]
City, State, Zip: [City, State, Zip]

RE: WORKERS' COMPENSATION MEDICAL RECORD REQUEST

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

Dear Medical Records Department / Dr. [Specialist Last Name],

Our office represents [Patient Name / Employer / Insurance Carrier] regarding a Workers' Compensation claim. We understand that the above-named patient was referred to your facility for specialist evaluation and/or treatment following their work-related injury.

Pursuant to [State/Local Law or Regulation], please provide copies of all medical records related to this patient, including but not limited to:

- Initial consultation and evaluation reports
- Diagnostic test results (X-rays, MRI, EMG, etc.)
- Progress notes and treatment plans
- Referral notes from the primary treating physician
- Work status reports and Functional Capacity Evaluations (FCE)
- Itemized billing statements

Please find the attached signed Authorization for Release of Medical Information. If there is a fee for these records, please provide an invoice and we will remit payment promptly. If the records are available in electronic format (PDF), please send them via [Email Address or Secure Portal].

Thank you for your prompt attention to this request. Please contact our office at [Phone Number] if you have any questions.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Organization]
[Phone Number]
[Email Address]

Enclosure: Signed Patient Authorization Form