[Date]

[Physical Therapy Clinic Name]
[Address Line 1]
[Address Line 2]
[Phone Number]

RE: Workers' Compensation Medical Record Request

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

To Whom It May Concern,

Please provide complete copies of all physical therapy medical records for the above-referenced patient regarding their workers' compensation claim. This request includes, but is not limited to:

- Initial Evaluations and Re-evaluations
- Daily Progress/Soap Notes
- Treatment Plans and Goals
- Attendance Records and Flowsheets
- Functional Capacity Evaluations (FCE), if applicable
- Discharge Summaries
- Itemized Billing Statements

Please send these records via [Fax/Email/Mail] to the following address:

[Your Name/Company Name]
[Mailing Address]
[City, State, Zip Code]
[Fax Number/Email Address]

Attached is the signed Medical Information Release Authorization (HIPAA) form provided by the patient.

If there are any fees associated with this request, please notify us before processing. If you have any questions, please contact [Contact Person Name] at [Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Role]