[Date]
[Medical Provider Name]
[Facility Name]
[Address Line 1]
[Address Line 2]

RE: REQUEST FOR MEDICAL RECORDS FOR INDEPENDENT MEDICAL EXAMINATION
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Claim Number: [Claim Number]
Date of Injury: [Date of Injury]

To the Medical Records Department,

Please be advised that [Name of Examining Doctor/Company] has been requested to perform an Independent Medical Examination (IME) regarding the above-referenced individual and their workers' compensation claim.

Under the applicable Workers' Compensation laws and the enclosed signed authorization, please provide copies of all medical records pertaining to the treatment of this patient, including but not limited to:

- Initial evaluation and consultation reports
- Progress notes and office visit records
- Diagnostic imaging reports (MRI, X-ray, CT scans)
- Operative reports and discharge summaries
- Physical therapy or rehabilitation records
- Work status notes and disability forms

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

[Requesting Company/Doctor Name]
[Return Address]
[Fax Number/Email Address]

If there is a fee for the reproduction of these records, please provide an invoice with the records or contact our office at [Phone Number] for payment arrangements.

Thank you for your prompt cooperation in this matter.

Sincerely,

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

Enclosure: Signed Patient Authorization for Release of Medical Information