Date: [Insert Date]

To: [Custodian of Records/Doctor Name]
Facility Name: [Insert Facility Name]
Address: [Insert Facility Address]

RE: Medical Record Request for Disability Rating
Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]
Claim Number: [Insert Workers Comp Claim Number]
Date of Injury: [Insert Date of Injury]

Dear Medical Records Department,

I am writing to formally request a complete copy of my medical records regarding the work-related injury mentioned above. These records are required for the purpose of determining a Permanent Partial Disability (PPD) rating or Permanent Impairment Rating.

Please provide the following documentation:

- All diagnostic imaging reports (X-rays, MRI, CT scans).
- Operative reports and surgical notes.
- Physical therapy progress notes and discharge summaries.
- Final clinical assessment and Maximum Medical Improvement (MMI) report.
- Any specific impairment rating evaluations performed.

I have attached a signed HIPAA-compliant release form authorizing the disclosure of these records. Please inform me of any copying fees associated with this request before processing.

Please send the records to:

[Your Name or Attorney Name]
[Mailing Address]
[City, State, Zip Code]
[Email Address/Phone Number]

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]