[Date]

[Clinic Name]
[Clinic Address]
[City, State, Zip Code]

RE: Request for Medical Records of Deceased Patient

Patient Name: [Full Name of Deceased]
Date of Birth: [Patient DOB]
Date of Death: [Patient Date of Death]
Social Security Number (Optional): [Patient SSN]

To whom it may concern,

I am writing to formally request a complete copy of the medical records for the above-named patient. I am the [Relation, e.g., Spouse, Child, Parent] of the deceased and am the authorized representative for their estate.

Please provide the following records: [e.g., All medical records, Lab results, Imaging reports, Discharge summaries] for the period of [Start Date] to [End Date].

I have enclosed the following documentation to verify my authority:

- A copy of the Death Certificate.
- Proof of identity (Copy of my Driver's License/ID).
- [Document proving legal authority, e.g., Letters of Administration, Small Estate Affidavit, or Power of Attorney with post-mortem clauses].

Please deliver these records via: [Email address or Mailing address].

If there are any fees associated with this request, please notify me in advance. You may reach me at [Phone Number] or [Email Address] if you require further information.

Sincerely,

[Your Signature]

[Your Printed Name]
[Your Address]