

[Your Full Name]
[Your Date of Birth]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

[Name of Doctor or Medical Facility]
[Department, if known]
[Address of Facility]

RE: Request for Complete Medical Records

To the Custodian of Records,

I am writing to formally request a complete copy of my medical records maintained by your facility. This request is made pursuant to my rights under HIPAA and relevant state laws.

Please provide all records pertaining to my care, including but not limited to:

- Complete physician notes and clinical summaries
- Diagnostic test results (lab work, imaging reports, and pathology)
- Imaging films or digital files (X-rays, MRIs, CT scans)
- Immunization records
- Prescription history
- Billing and insurance records

I would prefer to receive these records in [electronic format / paper format]. If there is a fee for the reproduction of these records, please notify me in advance if the cost exceeds \$[Amount].

Please send the records to the following address:

[Insert Mailing Address or Email Address here]

I look forward to receiving these records within the timeframe required by law. If you have any questions or require additional authorization forms, please contact me immediately.

Sincerely,

[Your Signature]

[Your Printed Name]