

DATE: [Insert Date]

TO: Custodian of Records
[Facility Name]
[Address]
[City, State, Zip Code]

RE: SUBPOENA DUCES TECUM
Patient Name: [Patient Name]
Date of Birth: [Patient Date of Birth]
Social Security Number: [Patient SSN (Optional)]
Case Number: [Court Case Number]

Dear Custodian of Records,

Enclosed please find a Subpoena Duces Tecum requesting the production of any and all medical records, including but not limited to dictated medical notes, physician entries, and electronic health records pertaining to the above-referenced individual for the period of [Start Date] to [End Date].

In accordance with this request, please provide a completed **Custodian of Records Affidavit** (enclosed) to certify the authenticity and accuracy of the records provided. This affidavit must be signed and notarized.

Please deliver the certified copies of the records and the signed affidavit to the following address on or before [Due Date]:

[Requesting Attorney/Entity Name]
[Mailing Address]
[City, State, Zip Code]

If there are any costs associated with the duplication of these records, please contact our office at [Phone Number] or [Email Address] prior to processing so that payment arrangements can be made.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]
[Your Title/Firm Name]

Enclosures:

1. Subpoena Duces Tecum

2. Custodian of Records Affidavit Form
3. Patient Authorization (if applicable)