[Date]

[Recipient Name]
[Recipient Title/Organization]
[Address Line 1]
[City, State, Zip Code]

RE: Certification of Medical Records

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]

To Whom It May Concern,

I, [Your Name], acting as the [Title/Custodian of Records] for [Name of Medical Facility], hereby certify that the attached medical records are true, complete, and accurate copies of the original records maintained by this facility.

These records were prepared by the personnel of [Name of Medical Facility] in the ordinary course of business at or near the time of the act, condition, or event described. They have been reproduced from the original files under my supervision and remain under my official custody.

The provided documentation includes:

- [List specific documents, e.g., Discharge Summaries]
- [List specific documents, e.g., Lab Results]
- [List specific documents, e.g., Imaging Reports]

Please contact our Records Department at [Phone Number] or [Email Address] if you require further verification or have any questions regarding these documents.

Sincerely,

[Signature]
[Typed Name]
[Title]
[Facility Name]

Notary Acknowledgement (if required):

Subscribed and sworn to before me this ____ day of _____, 20__.

_____
Notary Public