Current Date: [Insert Date]

Recipient Name: [Insert Recipient Name]
Facility/Provider Name: [Insert Facility Name]
Address: [Insert Address]
City, State, Zip: [Insert City, State, Zip]

RE: Secure Transmission of Patient Health Information (PHI)

Dear [Recipient Name],

Enclosed/Attached please find the protected health information for the following patient:

- Patient Name: [Insert Patient Name]
- Date of Birth: [Insert Date of Birth]
- Record Reference Number: [Insert ID Number, if applicable]

This information is being transmitted securely in compliance with HIPAA regulations for the purpose of [Insert Purpose, e.g., Continuity of Care / Referral / Insurance Verification].

Security Notice:
These files have been sent via [Insert Method, e.g., Secure Encrypted Email / Secure File Transfer Protocol / Password Protected Media]. If a password is required to access these files, it will be provided via a separate communication channel for security purposes.

Please confirm receipt of these files. If you have received this transmission in error, please notify the sender immediately and destroy the files without reviewing or distributing them.

For any questions regarding these records, please contact [Insert Contact Name] at [Insert Phone Number] or [Insert Email Address].

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title]
[Your Organization]

CONFIDENTIALITY NOTICE: This message and any attachments are intended only for the use of the individual or entity to which they are addressed and contain information that is privileged and confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.