[Your Organization Name]
[Department Name]
[Street Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Out-of-State Provider Name]
[Facility Name]
[Street Address]
[City, State, Zip Code]

RE: Initial Medical Record Request

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Social Security Number: [Last 4 Digits or N/A]
Date(s) of Service: [Start Date] to [End Date]

To the Medical Records Department,

We are writing to formally request a complete copy of the medical records for the above-referenced patient for the dates of service indicated. This request is for the purpose of [Reason: e.g., Continuing Care, Billing Audit, Legal Review].

Please provide the following documentation:

- Discharge Summary
- History and Physical
- Consultation Reports
- Operative Reports
- Laboratory and Diagnostic Test Results
- Progress Notes
- Itemized Billing Statement

Attached to this letter is a signed HIPAA-compliant Authorization for Release of Information. If there are any fees associated with this request, please notify us before processing or include an invoice with the records.

Please deliver the records via [Method: e.g., Secure Fax, Encrypted Email, or Postal Mail] to:

Recipient: [Name/Department]
Fax: [Fax Number]
Email: [Email Address]
Address: [Mailing Address]

Thank you for your prompt attention to this matter. If you have any questions, please contact [Contact Person Name] at [Phone Number].

Sincerely,

[Signature]
[Printed Name]
[Title]

Enclosure: Signed Patient Authorization Form