SECOND NOTICE

[Date]

[Provider Name]
[Facility Name]
[Address]
[City, State, Zip Code]

RE: [Patient Full Name]
Date of Birth: [Patient DOB]
Patient ID/Account Number: [ID Number, if known]

To Whom It May Concern,

This is a **SECOND NOTICE** regarding a request for medical records originally sent on [Date of First Request]. To date, we have not received the requested documentation or a notification of a delay.

Please provide copies of the following medical records for the period of [Start Date] to [End Date]:

- [Type of Record, e.g., Discharge Summary]
- [Type of Record, e.g., Operative Reports]
- [Type of Record, e.g., Lab Results and Imaging]

These records are required for [Purpose of Request, e.g., Continuity of Care / Legal Review / Insurance Processing].

Attached is a signed HIPAA-compliant authorization from the patient permitting the release of these records to our office. Please deliver the records via:

[Fax Number: (XXX) XXX-XXXX]
[Secure Email: email@address.com]
[Mailing Address: Street, City, State, Zip]

If there is a fee for this service, please contact us immediately so we can provide payment. If you have already sent these records, please disregard this notice.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name/Signature]
[Your Title]

[Your Organization Name]
[Your Phone Number]