Date: [Date]

To: [Name of Out-of-State Facility/Provider]
Address: [Street Address]
City, State, Zip: [City, State, Zip Code]
Phone/Fax: [Phone or Fax Number]

RE: HIPAA COMPLIANT MEDICAL RECORD REQUEST

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Social Security Number (Last 4): [Optional: XXX-XX-XXXX]
Patient Address: [Patient Current Address]

To Whom It May Concern,

I am writing to formally request a copy of my medical records pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR $ 164.524. Because I am requesting these records from out-of-state, please ensure they are delivered via the method indicated below.

Records Requested:

- [ ] All medical records for the period of [Start Date] to [End Date]
- [ ] Specific records only: [e.g., Imaging Reports, Lab Results, Discharge Summary]
- [ ] Billing records

Format & Delivery:

I request that these records be provided in the following format: [e.g., Digital PDF via Secure Email, CD/Flash Drive, or Paper Copies].

Please send the records to:

[Recipient Name/Doctor Office Name]
[Recipient Address]
[City, State, Zip Code]
[Recipient Email/Fax if applicable]

Authorization:

I understand that a reasonable, cost-based fee may be charged for labor and supplies associated with copying and mailing these records. Please notify me in advance if the total cost exceeds $[Amount].

Under HIPAA regulations, you are required to respond to this request within 30 days. If you require an extension or if any part of this request is denied, please provide a written explanation.

Thank you for your prompt attention to this matter.

Sincerely,

_____
[Signature of Patient or Legal Representative]

Printed Name: [Printed Name]
Relationship to Patient: [Self / Legal Guardian / Power of Attorney]