[Your Name]
[Your Address]
[Your City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[Medical Records Department Name]
[Hospital or Clinic Name]
[Street Address]
[City, State, Zip Code]

RE: Request for Out-of-State Surgical Records

To Whom It May Concern,

I am writing to formally request a copy of my surgical medical records for treatment received at your facility. I am currently residing out-of-state and require these documents for the continuity of my medical care.

Patient Identification Information:
Full Name: [Your Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/Account Number (if known): [ID Number]
Social Security Number (last 4 digits): [Last 4 Digits]

Specific Records Requested:
I am requesting records pertaining to the following surgery: [Name of Procedure/Surgery]
Approximate Date of Surgery: [Date or Date Range]
Surgeon Name: [Surgeon's Name]

Please include the following documents:
- Operative Reports
- Pathology Reports
- Discharge Summary
- Anesthesia Records
- Pre-operative and Post-operative Imaging/Scans

Please deliver these records via the following method:
[ ] Secure Email: [Your Email Address]
[ ] Standard Mail: [Your Current Mailing Address]

If there is a fee associated with this request, please notify me in advance. I have attached a signed HIPAA authorization form to this letter to verify my identity and consent.

Thank you for your prompt assistance in this matter.

Sincerely,

[Your Signature]

[Your Printed Name]