

Date: [Date]

To: [Facility/Provider Name]

Fax/Email: [Contact Information]

RE: Request for Past Surgical History

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Patient ID/SSN: [ID Number if applicable]

Dear Medical Records Department,

Our office is currently providing medical care for the patient listed above. To ensure continuity of care and accurate clinical assessment, we are requesting a comprehensive record of the patient's past surgical history.

Please provide the following documents:

- Operative Reports
- Discharge Summaries
- Pathology Reports (if applicable)
- Anesthesia Records
- Implant Logs (if applicable)

A signed patient authorization for the release of protected health information is attached to this request.

Please send the requested records via fax to [Fax Number] or via secure email to [Email Address].

Thank you for your prompt assistance in this matter.

Sincerely,

[Doctor Name/Provider Name]

[Clinic Name]

[Phone Number]