Date: [Current Date]

To: [Hospital Name]
Department: Medical Records / Health Information Management
Address: [Hospital Address]
Fax/Email: [Hospital Contact Details]

RE: Request for Surgical History and Operative Reports

Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Patient ID/MRN: [Patient Hospital ID Number, if known]
Dates of Service: [Date of Surgery or Range of Years]

To Whom It May Concern,

Our clinic is currently providing follow-up care for the above-named patient. To ensure continuity of care and accurate clinical assessment, we kindly request the following medical records regarding the patient's surgical history at your facility:

- Operative Reports
- Discharge Summaries
- Pathology Reports
- Anesthesia Records
- Post-Operative Imaging/Scans

Please send these documents via fax to **[Clinic Fax Number]** or via secure email to **[Clinic Email Address]**.

Attached to this request, you will find the signed Authorization for Release of Information (ROI) provided by the patient.

Thank you for your prompt assistance in this matter. If there are any questions, please contact our office at [Clinic Phone Number].

Sincerely,

[Doctor/Provider Name]
[Clinic Name]
[Clinic Address]