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

[Date]

[Insurance Company Name]
[Claims/Authorization Department]
[Insurance Company Address]
[City, State, Zip Code]

RE: Request for Medical Records Authorization

Patient Name: [Patient Full Name]
Policy Number: [Insurance ID Number]
Group Number: [Group Number]
Date of Birth: [MM/DD/YYYY]

To Whom It May Concern,

I am writing to formally request authorization for the release of medical records pertaining to [Patient Name]'s physical therapy and rehabilitation services.

The specific records requested include:

- Initial physical therapy evaluations
- Progress notes and daily treatment logs
- Plan of care and rehabilitation goals
- Discharge summaries (if applicable)
- Functional assessment results

These records are required for [state reason: e.g., continuing care, second opinion, or personal records]. The services were provided by [Clinic/Provider Name] between the dates of [Start Date] and [End Date].

I have enclosed a signed HIPAA-compliant release form authorizing the disclosure of this information. Please provide these records via [email/fax/mail] to the following address:

[Recipient Name/Facility]
[Recipient Address/Fax Number]

If there are any administrative fees associated with this request, or if further information is required, please contact me at [Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]