DATE: [Insert Date]

TO:
Custodian of Records
[Name of Facility/Clinic]
[Street Address]
[City, State, Zip Code]

RE: Authorization for Release of Records

PATIENT NAME: [Insert Patient Name]
DATE OF BIRTH: [Insert DOB]
SOCIAL SECURITY NUMBER: [Insert last 4 digits]
DATE(S) OF SERVICE: [Insert Dates or 'All']

Dear Custodian of Records,

This office represents the above-named patient regarding a legal matter. We request a complete certified copy of the patient's physical therapy and rehabilitation records.

Please provide the following documentation:

- Initial evaluations and assessment reports
- Daily treatment notes and flow sheets
- Progress summaries and discharge summaries
- Referrals and physician orders
- Itemized billing statements including CPT codes
- Any diagnostic imaging or testing results held within the file

Attached is a signed HIPAA-compliant authorization form executed by the patient granting permission for the release of these records to our firm.

If there is a fee for the reproduction of these records, please provide an invoice with the records or contact our office if the cost exceeds $[Insert Amount].

Please forward the requested documents to:

[Law Firm Name]
[Attn: Attorney/Paralegal Name]
[Mailing Address]
[Email Address for Digital Delivery]

Thank you for your prompt attention to this request.

Sincerely,

[Signature]
[Printed Name]
[Title]
[Law Firm Name]

Attachment: Signed HIPAA Authorization