

Date: [Date]

To: [Medical Provider Name/Facility Name]

Address: [Provider Address]

City, State, Zip: [Provider City, State, Zip]

RE: AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Social Security Number: [Last 4 Digits/Full SSN]

Date of Injury: [Date of Incident]

Claim Number: [Workers Comp Claim Number]

To Whom It May Concern,

This letter serves as a formal request for a complete copy of the medical records for the above-referenced patient regarding a Workers' Compensation claim. Our firm/agency has been authorized to obtain these records on behalf of [Client/Entity Name].

Please provide all records from [Start Date] to [End Date], including but not limited to:

- Physician notes and office visit summaries
- Diagnostic imaging reports (X-rays, MRI, CT scans)
- Physical therapy and rehabilitation records
- Operative reports and discharge summaries
- Itemized billing statements

Attached to this request, please find the signed HIPAA-compliant Third-Party Authorization form executed by the patient.

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

Please send the requested documentation to:

[Your Name/Company Name]

[Mailing Address]

[City, State, Zip]

[Email Address/Fax Number]

Thank you for your prompt attention to this matter.

Sincerely,

[Signature]
[Your Printed Name]
[Your Title]

Enclosure: Signed Authorization for Release of Information