

Date: [Date]

To: [Health Information Management/Medical Records Department]

Facility Name: [Name of Hospital or Clinic]

Address: [Facility Address]

City, State, Zip: [City, State, Zip Code]

RE: Authorization to Release Medical Records for Research Purposes

Patient Name: [Patient Full Name]

Date of Birth: [MM/DD/YYYY]

Patient ID/Medical Record Number: [Number, if known]

To Whom It May Concern,

I am writing to formally request the release of medical records for the above-named patient to be used in a clinical research study titled "[Full Title of Research Study]."

Attached to this letter, please find a signed and dated **HIPAA Authorization for Release of Information** form, specifically authorizing the disclosure of these records to the research team at [Name of Research Institution/University].

Please provide the following records for the period of [Start Date] to [End Date]:

- [e.g., Discharge Summaries]
- [e.g., Laboratory and Pathology Reports]
- [e.g., Imaging Reports and Scans]
- [e.g., Progress Notes]

Please deliver the requested records via the following method:

[] Secure Email/Electronic Portal: [Email Address]

[] Fax: [Fax Number]

[] Standard Mail: [Mailing Address]

If there are any fees associated with this request, or if further documentation is required, please contact our office at [Phone Number] or [Email Address].

Thank you for your assistance with this research effort.

Sincerely,

[Signature]

[Printed Name]

Title: [e.g., Principal Investigator / Study Coordinator]

Institution: [Research Institution Name]

Enclosure: Signed HIPAA Authorization Form