

**Date:** [Date]

**To:** [Medical Provider Name/Facility Name]

**Address:** [Provider Street Address]

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

**RE: REQUEST FOR MEDICAL RECORDS AND BILLING**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Patient DOB]

**Social Security Number:** [Last 4 Digits - Optional]

**Date of Incident/Service:** [Date Range of Records]

To Whom It May Concern:

Our law firm represents the above-named client regarding injuries sustained on [Date of Incident].

Attached please find a signed HIPAA-compliant Authorization for Release of Health Information. We request a complete copy of all medical records, including but not limited to:

- Emergency room records and intake notes;
- Physician and nursing progress notes;
- Diagnostic imaging reports (MRI, CT, X-ray);
- Physical therapy and rehabilitation records;
- Itemized billing statements showing all charges and payments.

Please provide these records in electronic format (PDF) if available. If there is a fee for these records, please notify our office or send an invoice along with the requested documents.

Thank you for your prompt attention to this matter.

Sincerely,

[Attorney Name]

[Law Firm Name]

[Phone Number]

[Email Address]

**Enclosure:** Signed Authorization for Release of Medical Information