

DATE: [Insert Date]

TO:

[Custodian of Records]

[Clinic/Facility Name]

[Street Address]

[City, State, Zip Code]

RE: FORMAL REQUEST FOR COMPLETE MEDICAL CHART AND AUDIT TRAIL

PATIENT NAME: [Insert Patient Name]

DATE OF BIRTH: [Insert Date of Birth]

SOCIAL SECURITY NUMBER: [Insert SSN - optional]

DATES OF SERVICE: [Insert Date Range]

To the Records Custodian,

This office represents [Client Name] regarding [Type of Legal Matter]. Pursuant to [Insert State/Federal Law, e.g., HIPAA or State Statute], we hereby request a complete and certified copy of the patient's entire medical record for the dates of service listed above.

This request specifically includes, but is not limited to, the following:

- All clinical notes, physician orders, and nursing assessments.
- All diagnostic imaging, laboratory results, and pathology reports.
- All intake forms, consent forms, and insurance information.
- **The Full Audit Trail/Audit Log:** Including metadata showing the identity of individuals who accessed, viewed, edited, or deleted entries; the date and time of each action; and the specific workstation used.
- All internal communications, emails, and "sticky notes" regarding the patient.
- Billing statements and itemized charges.

Please provide these records in their original electronic format (PDF or XML) if possible. If there is a fee for the reproduction of these records, please provide an invoice or contact our office immediately if the cost exceeds \$[Insert Amount].

Enclosed, please find a signed Authorization for Release of Information executed by the patient. Failure to comply with this request within [Insert Number, e.g., 30] days may result in further legal action to compel production.

Sincerely,

[Your Signature]

[Printed Name]

[Law Firm Name]

[Phone Number]

[Email Address]

Enclosure: Signed Patient Authorization