Date: [Insert Date]

To: [Clinic/Hospital Name]
Department: Medical Records Department
Address: [Clinic Address]

RE: EXPEDITED REQUEST FOR MEDICAL RECORDS

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Patient ID/Chart Number: [Patient ID Number, if known]

To whom it may concern,

I am writing to formally request a copy of my medical records. This request is **urgent** as these records are required for an upcoming surgery scheduled for [Date of Surgery].

Please provide the following records from [Start Date] to [End Date]:

- Operative reports and surgical notes
- Diagnostic imaging results (MRI, CT, X-Ray)
- Laboratory and blood work results
- Current medication list and allergies
- Physician consultation notes

Please deliver these records via the following method:

[ ] Secure Email: [Insert Email Address]
[ ] Fax: [Insert Fax Number]
[ ] Physical Pickup

I have attached a signed authorization form for the release of protected health information. Given the scheduled surgery date, I kindly request that these records be processed within [Number] business days.

Please contact me immediately at [Phone Number] if there are any fees or additional forms required to complete this request.

Sincerely,

[Your Signature]
[Your Printed Name]