

[Sender Name/Law Firm Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Recipient Name/Risk Management Department]
[Facility/Provider Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]

RE: Notice of Investigation into Medical Malpractice Claim

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date(s) of Incident: [Date range of treatment]
Patient ID/Account Number: [If known]

To Whom It May Concern,

Please be advised that this office has been retained to investigate a potential medical malpractice claim against [Provider/Facility Name] arising from the care and treatment provided to [Patient Name] on or about the dates mentioned above.

The focus of our investigation concerns [Briefly state the nature of the incident, e.g., surgical error, failure to diagnose, or medication error]. It is alleged that the standard of care was breached, resulting in [Briefly describe injuries or damages].

Notice to Preserve Evidence:

You are hereby instructed to preserve all records related to this patient, including but not limited to: medical records, nursing notes, imaging studies, lab results, billing records, internal communications (emails/memos), and any physical evidence or equipment involved in the incident. Do not alter, delete, or destroy any such records.

Request for Records:

Enclosed is a signed HIPAA-compliant authorization for the release of the patient's complete medical file. Please provide these records to our office within [Number] days.

We invite you to forward this letter to your professional liability insurance carrier. All future correspondence regarding this matter should be directed to our office.

Sincerely,

[Signature]
[Printed Name]
[Title/Firm]

Enclosure: HIPAA Authorization Form