[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Medical Provider Name]
[Facility Name]
[Address]
[City, State, Zip Code]

RE: Authorization for Release of Medical Records
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Injury: [Date of Injury]
Workers' Compensation Claim Number: [Claim Number]

To Whom It May Concern,

I am writing to formally request a complete copy of my medical records regarding the injury sustained on the date mentioned above. These records are required for my Workers' Compensation claim.

Please provide all records from [Start Date] to [End Date/Present], including but not limited to:

- Physician notes and evaluation reports
- Diagnostic imaging results (X-rays, MRI, CT scans)
- Physical therapy and rehabilitation records
- Prescription and medication logs
- Itemized billing statements

Please send these records to:

[Recipient Name/Entity]
[Mailing Address]
[Email/Fax Number]

If there is a fee for copying these records, please notify me in advance. I have attached a signed medical authorization form for your files.

Thank you for your prompt attention to this request.

Sincerely,

[Signature]

[Your Printed Name]