[Your Name]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

[Name of Medical Provider/Facility]
[Department, e.g., Medical Records Department]
[Address of Facility]

RE: Request to Inspect and Copy Health Records
Patient Name: [Your Full Name / Patient Name]
Date of Birth: [Your Date of Birth]
Patient Account/ID Number: [Optional: Your ID Number]

To the Records Custodian,

I am writing to formally request access to my health records maintained by your facility, as is my right under the Health Insurance Portability and Accountability Act (HIPAA) and applicable state laws.

I am requesting to (check all that apply):
[ ] Inspect my original records in person.
[ ] Receive a copy of my records.

Please provide the following records for the period of [Start Date] to [End Date]:
[List specific records, e.g., Physician notes, lab results, imaging reports, billing records]

I would prefer to receive these records in the following format:
[e.g., Paper copies via mail, Electronic copies via secure email, or Electronic copies on a CD/USB drive]

I understand that you may charge a reasonable, cost-based fee for the labor and supplies required to copy and mail these records. Please notify me in advance if the total cost will exceed $[Insert Amount].

Please let me know when the records will be available for inspection or when I can expect to receive the copies. Under HIPAA, I look forward to a response within 30 days.

Sincerely,

[Your Signature]

[Your Printed Name]