

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

[Date]

[Custodian of Records or Provider Name]  
[Facility Name]  
[Facility Address]  
[City, State, Zip Code]

**RE: Request for Medical Records**

Patient Name: [Patient Full Name]  
Date of Birth: [MM/DD/YYYY]  
Patient ID/Account Number: [Optional]

To Whom It May Concern,

I am writing to formally request a copy of my medical records from [Start Date] to [End Date].

Specifically, please include the following documents:

- Office visit notes
- Laboratory test results
- Imaging reports (X-ray, MRI, CT)
- Discharge summaries
- Prescription history

I would prefer to receive these records in [electronic format/paper format]. If there is a fee associated with this request, please notify me of the cost before processing.

Under HIPAA regulations, I understand that these records should be provided within 30 days. If you have any questions or require a signed authorization form, please contact me immediately.

Thank you for your assistance.

Sincerely,

[Your Signature]

[Your Printed Name]