[Attorney Name/Law Firm Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email]

[Date]

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

[Name of Healthcare Provider/Hospital/Clinic]
[Address]
[City, State, Zip Code]

RE: NOTICE OF REPRESENTATION AND PRESERVATION OF RECORDS

Client: [Patient Full Name]
Date of Birth: [DOB]
Incident Date(s): [Dates of Care]
Subject: Potential Medical Malpractice Claim

To Whom It May Concern:

Please be advised that this office has been retained to represent [Patient Full Name] in connection with a medical malpractice claim arising from treatment provided by [Name of Provider/Facility] on or about [Date].

Pursuant to this representation, we request that you forward this letter immediately to your professional liability insurance carrier and your legal counsel. Please direct all future communications regarding this matter solely to this office.

I. Request for Records
Enclosed is a signed HIPAA-compliant authorization form. Please provide a complete copy of all medical records, including but not limited to: physician notes, nursing notes, surgical reports, diagnostic imaging (in DICOM format), lab results, billing statements, and pharmacy records.

II. Preservation of Evidence
You are hereby notified to preserve all evidence related to the care of [Patient Name]. This includes original paper charts, electronic health records (EHR) including metadata and audit trails, emails, text messages, internal communications, and any physical evidence or equipment involved in the incident. Do not alter, delete, or destroy any records related to this patient.

Please acknowledge receipt of this letter in writing within [Number] days. We look forward to your cooperation.

Sincerely,

[Attorney Signature]

[Attorney Name]
[Law Firm Name]

Enclosure: HIPAA Authorization Form