[Attorney Name/Law Firm]
[Address Line 1]
[Address Line 2]
[Phone Number]
[Email Address]

[Date]

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

RE: Letter of Representation and Request for Records

Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Date of Incident/Injury: [Date of Incident]
Patient Account Number: [Account Number, if known]

To Whom It May Concern,

Please be advised that this office represents the above-named patient in a legal matter regarding injuries sustained on or about [Date of Incident].

We kindly request that you direct all future correspondence regarding this patient's treatment, billing, and liens to our office. Do not discuss this matter directly with our client without our express written consent.

Pursuant to the attached HIPAA-compliant authorization, please provide a complete copy of the following records:

- All medical records, including office notes and reports.
- Diagnostic imaging (X-rays, MRIs, CT scans) and related reports.
- Itemized billing statements showing all charges and payments.
- Physical therapy or rehabilitation records.

Please forward these documents to our office at the address listed above. If there is a fee for the duplication of these records, please send an invoice or contact our office for payment.

Thank you for your prompt attention to this matter.

Sincerely,

[Signature]
[Printed Name of Attorney]
[Law Firm Name]

Enclosure: HIPAA Authorization Form