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

[Date]

[Medical Provider Name]
[Records Department Address Line 1]
[Records Department Address Line 2]

RE: Notice of Representation and Request for Medical Records

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Social Security Number: [Last 4 Digits or Full SSN]
Date of Incident/Service: [Date Range]

To Whom It May Concern,

Please be advised that this office represents [Patient Name] regarding injuries sustained on or about [Date].

We kindly request a complete copy of all medical records and billing statements pertaining to the treatment of our client. This request includes, but is not limited to:

- Admission and discharge summaries
- Physician progress notes and consultations
- Diagnostic imaging reports (MRI, CT, X-ray) and actual films/CDs
- Laboratory test results
- Prescription and medication logs
- Itemized billing statements showing all charges, payments, and adjustments

Attached is a signed HIPAA-compliant authorization form executed by the patient, permitting the release of these records to our office.

Please forward the requested documents to our address listed above. If there is a fee for the reproduction of these records, please provide an invoice or contact our office so that payment can be arranged promptly.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Title]

Enclosure: Signed HIPAA Authorization