DATE: [Insert Date]

TO:
[Hospital Name]
[Department, e.g., Records Department / Legal Department]
[Hospital Address]
[City, State, Zip Code]

RE: NOTICE OF REPRESENTATION AND AUTHORIZATION

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert DOB]
Patient ID/Account Number: [Insert Number, if known]

To Whom It May Concern,

Please be advised that I, [Patient Name], have officially retained and authorized [Name of Representative/Attorney/Organization] to act as my formal representative in all matters regarding my medical care, billing, and legal interests associated with [Hospital Name].

Effective immediately, please direct all future correspondence, medical records requests, and inquiries regarding my treatment or accounts to my representative at the following address:

Representative Name: [Insert Name]
Company/Firm: [Insert Firm Name, if applicable]
Address: [Insert Address]
Phone Number: [Insert Phone]
Email: [Insert Email]

Attached to this letter, please find a signed HIPAA Release Form authorizing the disclosure of my Protected Health Information (PHI) to the aforementioned party. This authorization includes, but is not limited to, medical records, diagnostic imaging, billing statements, and physician notes.

Please update your records to reflect this representation. No further direct contact should be made with me regarding [Specific Incident or All Records] without the express presence or consent of my representative.

Thank you for your prompt attention to this matter.

Sincerely,

_____
[Patient Signature or Legal Guardian Signature]

[Printed Name of Patient/Guardian]