

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

[Date]

[Physician Name]
[Practice Name]
[Address]
[City, State, Zip Code]

RE: Letter of Representation / Request for Records

Patient Name: [Patient/Client Name]
Date of Birth: [DOB]
Date of Incident: [Date of Accident/Injury]

Dear Dr. [Physician Last Name],

Please be advised that this office represents [Patient Name] in connection with injuries sustained on the date referenced above. We are currently investigating a legal claim on behalf of our client.

Attached please find a signed HIPAA-compliant authorization form executed by our client, which permits you to release their medical information to this office.

We request that you provide us with a complete copy of the patient's medical file, including but not limited to:

- All office notes and clinical records;
- Diagnostic test results and imaging reports (MRI, X-ray, CT scans);
- Consultation reports and referrals;
- Itemized billing statements for all services rendered to date.

Please forward the requested documents to our office at your earliest convenience. If there is a fee for the duplication of these records, please send an invoice along with the records, or notify us in advance of the cost.

Additionally, we request that you do not discuss this patient's condition, treatment, or prognosis with any insurance company or their representatives without first contacting our office.

Thank you for your time and for the care you have provided to our client. If you have any questions, please feel free to contact my office.

Sincerely,

[Attorney Signature]

[Attorney Printed Name]

Enclosure: Signed Medical Authorization