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

[Date]

[Name of Records Custodian/Facility Name]
[Medical Records Department]
[Street Address]
[City, State, Zip Code]

RE: LETTER OF REPRESENTATION AND REQUEST FOR MEDICAL RECORDS

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

To the Custodian of Medical Records:

Please be advised that this office represents the above-named patient in a legal matter. Attached to this letter, please find a signed HIPAA-compliant authorization form executed by the patient, permitting the release of their protected health information to our firm.

We hereby request a complete copy of any and all medical records in your possession pertaining to the patient for the dates of service listed above, including but not limited to:

- Admission and discharge summaries
- Progress notes and physician orders
- Diagnostic test results and imaging reports (MRI, CT, X-ray)
- Operative reports and pathology findings
- Itemized billing statements and insurance claim forms
- Pharmacy and medication records

Please provide these records in electronic format (PDF) if possible. If there is a fee for the reproduction of these records, please provide an invoice or contact our office immediately so that we may facilitate payment.

Thank you for your prompt attention to this matter. Please contact us if you require any further information.

Sincerely,

[Your Signature]
[Your Printed Name]
[Title/Law Firm Name]

Enclosure: Signed HIPAA Authorization Form