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

[Date]

Custodian of Records
[Pharmacy Name]
[Pharmacy Address]
[City, State, Zip Code]

RE: LETTER OF REPRESENTATION AND REQUEST FOR RECORDS

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

To the Custodian of Records:

Please be advised that this office represents the above-named patient in a legal matter. We have enclosed a signed HIPAA-compliant authorization form allowing you to release the patient's protected health information to our firm.

We hereby request copies of any and all pharmacy records for the period of [Start Date] to [End Date]. These records should include, but are not limited to:

- Prescription profiles and dispensing logs;
- Prescribing physician names and contact information;
- Dosage instructions and quantity dispensed;
- Method of payment and insurance information;
- Pharmacist consultation notes or counseling logs.

If there is a fee for the production of these records, please provide an invoice or contact our office for payment before processing. Please provide these records in electronic format if possible.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Name/Attorney Name]
[Law Firm Name]

Enclosure: Signed HIPAA Authorization