

**Date:** [Date]

**To:** [Requesting Party Name]

**Address:** [Street Address]

**City, State, Zip:** [City, State, Zip]

**RE: Medical Records Request Status**

**Patient Name:** [Patient Name]

**Date of Birth:** [Patient Date of Birth]

**Request Reference Number:** [Reference Number]

Dear [Requester Name],

We are writing to inform you that we are unable to process your request for medical records at this time because the HIPAA authorization provided has expired.

According to our records, the authorization on file expired on [Expiration Date]. To protect patient privacy and comply with federal and state regulations, we require a current and valid authorization to release medical information.

**To proceed with this request, please provide:**

- A newly signed and dated HIPAA-compliant authorization form.
- Ensure the authorization includes the patient's current signature or the signature of a legal representative.

Once we receive the updated documentation, we will process your request promptly. If you have any questions, please contact our Medical Records Department at [Phone Number].

Sincerely,

[Staff Name/Department]

[Facility Name]

[Contact Information]