[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Date]

[Name of Healthcare Provider/Facility]
[Department Name, e.g., Medical Records Department]
[Address]
[City, State, Zip Code]

RE: Letter of Instruction for Release of Medical and Billing Records

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/Account Number: [Account Number, if known]

To Whom It May Concern,

I am writing to formally instruct your facility to release a complete copy of my medical and billing records. Please provide records for the following period of treatment: [Start Date] to [End Date/Present].

This request includes, but is not limited to, the following items:

- Complete medical history and physical examinations.
- Physician and nursing progress notes.
- Diagnostic test results (Labs, X-rays, MRI, CT scans).
- Surgical and operative reports.
- Discharge summaries.
- Itemized billing statements and payment history.
- Insurance claim forms and correspondence.

Please deliver these records to the following recipient:

[Recipient Name/Organization]
[Recipient Address]
[Recipient Email/Fax Number]

I request that these records be provided in [Digital/PDF or Paper] format. If there is a reasonable fee for the duplication of these records, please notify me in advance or include the invoice with the sent records.

This authorization is valid for [Number] days from the date of signature. I understand that I have the right to revoke this request in writing at any time.

Thank you for your prompt attention to this matter.

Sincerely,

[Signature]

[Printed Name]