[Your Name/Organization Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Recipient Name/Medical Records Department]
[Healthcare Facility Name]
[Facility Address]
[City, State, Zip Code]

RE: Instruction for Submission of Medical Records
Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/Account Number: [Number, if known]

To Whom It May Concern,

This letter serves as a formal instruction to submit the medical records of the above-named patient to the designated recipient listed below. Please provide all records pertaining to [Specific Date Range or Treatment Type, e.g., all records from 2022 to present].

Please submit the records to:
Recipient Name: [Name of Individual or Entity]
Attention: [Department/Specific Person]
Delivery Address: [Full Mailing Address]
Fax Number: [Fax Number, if applicable]
Secure Email/Portal: [Email Address, if applicable]

The requested records should include, but are not limited to:

- Diagnostic test results and lab reports
- Physician notes and consultation summaries
- Imaging reports (X-rays, MRI, CT scans)
- Immunization records
- Prescription history

Please ensure these records are delivered no later than [Date]. I have attached a signed Authorization for Release of Information form as required by HIPAA regulations.

If there are any fees associated with this request or if you require further clarification, please contact me immediately at [Your Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Relationship to Patient, e.g., Self, Legal Representative]