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

[Date]

[Treating Provider Name, e.g., Dr. John Smith]
[Practice/Facility Name]
[Department, if applicable]
[Street Address]
[City, State, Zip Code]

RE: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN, if known]

Dear [Provider Last Name],

[Insert reason for correspondence, such as a request for medical records, a referral, or a follow-up inquiry regarding treatment].

[Insert specific details or instructions].

Thank you for your assistance and your commitment to the patient's care.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Role]