Patient Record Verification Notice

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Address: [Insert Patient Address]

Dear [Insert Patient Name],

We are writing to notify you about the verification of your medical records. As part of our commitment to maintaining accurate patient information, we request your assistance in confirming the details of your records.

Please review the attached records and verify the following information:

- Date of Birth: [Insert DOB]
- Address: [Insert Address]
- Phone Number: [Insert Phone Number]

If any of the above information is incorrect or if your records require updates, please contact our office within [Insert Time Frame] at [Insert Contact Number].

Your prompt attention to this matter is greatly appreciated.

Sincerely,

[Insert Your Name]

[Insert Your Title]

[Insert Facility Name]

[Insert Contact Information]