Health Information Retrieval Request

Date: [Insert Date]

[Recipient's Name]

[Recipient's Title]

[Hospital/Clinic Name]

[Hospital/Clinic Address]

Dear [Recipient's Name],

I am writing to formally request the retrieval of my health information as permitted under [specify relevant laws or regulations].

Patient Information:

- Name: [Your Full Name]
- Date of Birth: [Your Date of Birth]
- Patient ID: [Your Patient ID (if applicable)]

I am specifically requesting copies of the following records:

- [Specify types of records, e.g., medical history, test results, treatment records]

Please send the requested information to the following address:

[Your Address]

If you require any additional information to process my request, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Signature (if sending a hard copy)]