Medical History Documentation Application

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email]

[Your Phone Number]

[Recipient's Name]

[Recipient's Title]

[Medical Institution's Name]

[Institution's Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to request my medical history documentation for the purpose of [reason for request, e.g., transferring to another provider, personal records, etc.]. My date of birth is [Your Date of Birth] and my patient ID number is [Your Patient ID Number] (if applicable).

In accordance with HIPAA regulations, I would appreciate your assistance in providing me with a copy of my medical records, including but not limited to:

- All past medical history
- Recent lab results
- Any imaging studies
- Consultation reports

Please let me know if there are any forms or identification required to process this request. I am willing to cover any associated costs for copying and sending these documents.

Thank you for your prompt attention to this matter. I look forward to your reply.

Sincerely,

[Your Name]