Medical History Release Request

Date: [Insert Date]

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

[Recipient's Name]
[Recipient's Title or Department]
[Healthcare Facility Name]
[Facility Address]
[City, State, Zip Code]

Dear [Recipient's Name],

I, [Your Name], hereby request the release of my medical history records as outlined below. This request is made in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Patient Information:
Full Name: [Your Full Name]
Date of Birth: [Your Date of Birth]
Patient ID: [Your Patient ID if applicable]

Records Requested:
[Specify the type of medical records needed, e.g., "all records", "specific treatment records", etc.]
[Specify the time period for records, e.g., "from January 1, 2020, to present"]

Please send the requested medical records to the address provided above or via my email at [Your Email Address]. Should you require any further information or forms to process this request, please do not hesitate to contact me.

Thank you for your prompt attention to this matter.

Sincerely,
[Your Signature (if sending a hard copy)]
[Your Printed Name]