Application for Retrieving Clinical Records

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Recipient's Name]

[Hospital/Clinic Name]

[Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request a copy of my clinical records as per my rights under the Health Insurance Portability and Accountability Act (HIPAA). My details are as follows:

- **Name:** [Your Full Name]
- **Date of Birth:** [Your Date of Birth]
- **Patient ID:** [Your Patient ID or Number if applicable]
- **Dates of Treatment:** [Specify range of dates, if known]

Please send the records to my address listed above or via email at [Your Email Address]. If there is a fee for processing this request, please let me know in advance.

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

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]