Letter of Demand for Medical History

Date: [Insert Date]

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

[Recipient's Name]
[Medical Facility/Provider's Name]
[Facility Address]
[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request a complete copy of my medical history 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]
Medical Record Number: [Your MRN, if applicable]

I would like to receive copies of my medical records from [specific dates or range, if applicable]. Please include all relevant information, including but not limited to, diagnostic reports, treatment history, and medication prescriptions.

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

Sincerely,

[Your Name]