Inquiry for Release of Health Information

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Recipient's Name]

[Recipient's Title]

[Institution Name]

[Institution Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request the release of my health information as permitted under the Health Insurance Portability and Accountability Act (HIPAA). My details are as follows:

Name: [Your Full Name]

Date of Birth: [Your DOB]

Patient ID (if applicable): [Your Patient ID]

I would like to request the following information:

- [Type of health information needed]
- [Specific dates or range of dates]

Please send the requested information to my address listed above or to my email at [Your Email Address]. If you need any further information or documentation to process my request, please let me know.

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

Sincerely,

[Your Name]