

# Request for Medical Records

Date: [Insert Date]

[Recipient's Name]

[Recipient's Title]

[Facility/Practice Name]

[Facility/Practice Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request access to my personal medical records in accordance with the Health Insurance Portability and Accountability Act (HIPAA). My details are as follows:

Name: [Your Full Name]

Date of Birth: [Your Date of Birth]

Address: [Your Address]

Phone Number: [Your Phone Number]

Please send me a copy of my medical records covering the period from [Start Date] to [End Date]. If there are any fees for copying or sending the records, kindly inform me beforehand.

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

Sincerely,

[Your Name]

[Your Signature (if sending a hard copy)]