Request for Copies of Medical Records

Date: _____

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

[Recipient's Name]
[Name of Medical Facility or Doctor]
[Facility Address]
[City, State, ZIP Code]

Dear [Recipient's Name],

I am writing to formally request copies of my medical records for the purpose of obtaining a second opinion regarding my health condition. My full name is [Your Full Name], and my date of birth is [Your Date of Birth].

Please include all pertinent information regarding my medical history, treatments, and any diagnostic test results from my visits dated [specific dates or date range].

If there are any forms or fees required to process this request, please inform me at your earliest convenience so I can comply promptly.

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

Sincerely,

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