Application for Certified Health Documents

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Recipient's Name]

[Facility/Organization's Name]

[Facility/Organization's Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request certified copies of my health documents. My details are as follows:

- **Name:** [Your Full Name]
- **Date of Birth:** [Your Date of Birth]
- **Patient ID:** [Your Patient ID (if applicable)]
- **Date of Visit:** [Date of the visit or hospitalization]

These documents are needed for [state the purpose, e.g., insurance claims, legal reasons, etc.]. I appreciate your prompt attention to this matter.

Please let me know if there are any forms to complete or fees required for the processing of this request.

Thank you for your assistance.

Sincerely,

[Your Name]