

# Request for Certified Health Records

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email Address]

[Your Phone Number]

To Whom It May Concern,

I am writing to formally request a copy of my certified health records as permitted under [Insert relevant law or regulation, e.g., HIPAA]. My details are as follows:

Name: [Your Full Name]

Date of Birth: [Your Date of Birth]

Address: [Your Current Address]

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

Please send my records to the address mentioned above, or to my email address [Insert email] if possible. I understand that there may be a processing fee, and I am willing to cover any necessary expenses.

If you require any additional information or identification to process my request, please let me know at your earliest convenience.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]