Request for Certified Copies of Medical Records

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]

To:

[Medical Facility Name]

[Facility Address]

[City, State, Zip Code]

Dear [Recipient's Name or "Medical Records Department"],

I am writing to formally request certified copies of my medical records. Below are my details:

Patient Name: [Your Full Name]

Date of Birth: [Your Date of Birth]

Medical Record Number: [If known]

Dates of Treatment: [Specify the dates if applicable]

Please send the requested records to my address listed above or via email at [Your Email Address]. I understand that there may be a fee for copying and mailing these records, and I am willing to cover these costs.

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]