Medical Records Request Denial

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email]

[Your Phone Number]

[Recipient's Name]

[Recipient's Title]

[Institution Name]

[Institution Address]

[City, State, Zip Code]

Dear [Recipient's Name],

We are writing to inform you that your request for access to medical records dated [Insert Request Date] has been denied due to insufficient identification.

According to our policy, we require proper identification to ensure the confidentiality and security of patient information. Unfortunately, the identification provided did not meet our requirements.

To proceed with your request, please provide a valid form of identification, which may include:

- Government-issued photo ID
- Utility bill or bank statement with your name and address
- Any other legal document proving your identity

Once we receive the required identification, we will be happy to process your request promptly.

If you have any questions or need further assistance, please feel free to contact us at [Insert Contact Number] or [Insert Email Address].

Thank you for your understanding.

Sincerely,

[Your Name]

[Your Title]

[Institution Name]