Denial of Medical Records Request

Date: [Insert Date]

[Recipient's Name]

[Recipient's Address]

[City, State, Zip Code]

Dear [Recipient's Name],

Thank you for your recent request for access to medical records pertaining to [Patient's Name]. After careful consideration, we regret to inform you that we are unable to fulfill your request.

As per [insert applicable law or policy], medical records can only be released to the patient or their authorized representative. Since you are not the patient or a designated representative, we cannot provide the records you requested.

If you believe this decision is incorrect or if you have any questions regarding this matter, please feel free to contact our office at [insert contact number] or [insert email address].

Thank you for your understanding.

Sincerely,

[Your Name]

[Your Title]

[Healthcare Facility Name]

[Facility Address]

[City, State, Zip Code]