Medical Records Request Denial

Date: [Insert Date]

[Your Name]
[Your Title/Position]
[Facility Name]
[Facility Address]
[City, State, Zip Code]

[Recipient's Name]
[Recipient's Address]
[City, State, Zip Code]

Dear [Recipient's Name],

Thank you for your request for medical records dated [Insert Request Date]. We appreciate your interest in obtaining your medical information.

After careful consideration, we regret to inform you that we are unable to fulfill your request for the following reasons:

- The requested records are restricted under our facility's policy.
- Access to certain medical records can only be granted under specific circumstances.

We understand this may be disappointing, and we encourage you to contact us for further clarification on our policies or to discuss potential alternatives. Please feel free to reach out at [Facility Phone Number] or [Facility Email Address].

Thank you for your understanding.

Sincerely,

[Your Name]
[Your Title/Position]
[Facility Name]