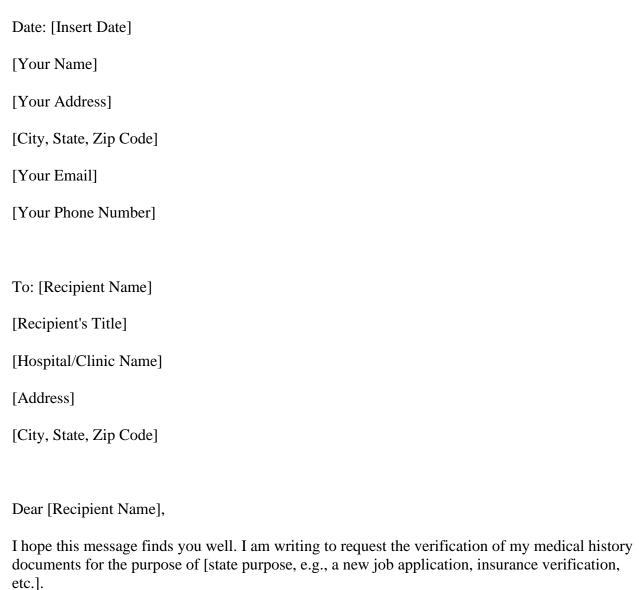
Patient History Document Verification Request



Below are my details for your reference:

- Full Name: [Patient's Full Name]
- Date of Birth: [Patient's DOB]
- Medical Record Number: [MRN or ID Number]
- Date of Service: [Dates relevant to the documents requested]

Kindly verify and, if necessary, send the relevant documents to my email or mailing address provided above. If you require any further information, please do not hesitate to contact me.

Thank you for your prompt attention to this matter.
Sincerely,
[Your Name]