Patient History Document Verification Request

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email]

[Your Phone Number]

To: [Recipient Name]

[Recipient's Title]

[Hospital/Clinic Name]

[Address]

[City, State, Zip Code]

Dear [Recipient Name],

I hope this message finds you well. I am writing to request the verification of my medical history documents for the purpose of [state purpose, e.g., a new job application, insurance verification, etc.].

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]