Medical History Confirmation Request

Date: [Insert Date]

To: [Recipient's Name]

[Recipient's Title]

[Recipient's Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to request confirmation of the medical history of my patient, [Patient's Name], who has been under my care since [Start Date]. This information is crucial for their ongoing treatment and well-being.

Please provide the following details:

- Previous diagnoses
- Treatment history
- Medications prescribed
- Allergies and adverse reactions

Should you require any further information or clarification, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Hospital/Practice Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]