Request for Patient Health Record Verification

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Recipient's Name]

[Recipient's Title]

[Hospital/Clinic Name]

[Hospital/Clinic Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request verification of my health records for the purpose of [reason for verification, e.g., transferring to a new provider, insurance purposes, etc.]. My details are as follows:

Patient Name: [Patient's Full Name]

Date of Birth: [Patient's Date of Birth]

Patient ID/Medical Record Number: [Patient ID/Record Number]

Kindly verify and provide confirmation of my health records as they are crucial for [explain the reason why you need verification]. I appreciate your prompt attention to this matter.

If you require any more information to process this request, please feel free to contact me at the phone number or email address listed above.

Thank you for your assistance.

Sincerely,

[Your Name]