Responsible Party Identification for Medical Records

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]

To Whom It May Concern,

I, [Your Name], am writing to formally identify myself as the responsible party for the medical records of:

Patient's Name: [Patient's Name]

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

Patient ID (if applicable): [Patient ID]

As the responsible party, I request access to the patient's medical records for the purpose of managing their healthcare. I understand the importance of confidentiality and assure you that any information received will be handled in accordance with HIPAA regulations.

Attached are the necessary identification documents to verify my relationship and authority as the responsible party.

If you require any further information or documentation to process this request, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].

Thank you for your attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]