

Medical Records Request Response

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Address: [Insert Patient Address]

Phone Number: [Insert Phone Number]

Dear [Insert Patient Name],

We have received your request for your medical records dated [Insert Request Date]. We are committed to ensuring that you have access to your medical information. This letter serves as confirmation that we are processing your request.

In order to fulfill your request, please ensure the following:

- Provide any necessary identification to verify your request.
- Specify the records you wish to obtain (e.g., dates of service, specific providers).
- Include any applicable fees for processing your request.

Upon receipt of the required information, we will make every effort to respond to your request as promptly as possible, typically within [Insert Time Frame].

If you have any questions or require further assistance, please do not hesitate to contact our office at [Insert Contact Number] or [Insert Email Address].

Thank you for your patience and understanding.

Sincerely,

[Insert Your Name]

[Insert Your Title]

[Insert Medical Facility Name]

[Insert Medical Facility Address]