Medical Records Request

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]

[Recipient's Name]

[Recipient's Organization]

[Organization's Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request a copy of my medical records for the purpose of submitting a claim to my insurance provider. Below are the details regarding my request:

- Patient Name: [Your Full Name]
- Date of Birth: [Your Date of Birth]
- Medical Record Number: [If applicable]
- Dates of Treatment: [Specify dates or general time frame]

Please send the requested records to the address listed above, or inform me if these can be sent electronically to my email address.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]