Medical Records Request for Second Opinion

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email]

[Your Phone Number]

[Recipient's Name]

[Medical Facility's Name]

[Facility'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 obtaining a second opinion regarding my health condition. My name is [Your Full Name], and I was treated at your facility under the care of Dr. [Doctor's Name] on [Date(s) of Service]. My date of birth is [Your Date of Birth].

Please send my medical records to the address listed above or to my email at [Your Email]. If you require any further information or forms to be filled out to process this request, do not hesitate to contact me.

Thank you for your assistance in this matter.

Sincerely,

[Your Name]