# Medical Record Request

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]

To Whom It May Concern,

I am writing to formally request copies of my medical records for the purpose of obtaining a second opinion regarding my ongoing treatment. Below are my details for your reference:

**Patient Name:** [Your Full Name]

**Date of Birth:** [Your Date of Birth]

**Patient ID (if applicable):** [Your Patient ID]

**Dates of Treatment:** [Specify Dates]

Please include all relevant information such as diagnosis, treatment history, and test results in your response. I would like to have the records sent to my email address or my mailing address as listed above.

Thank you for your prompt attention to this matter. If you require further verification or information, please feel free to contact me at the provided phone number or email address.

Sincerely,

[Your Name]