

Request for Medical History

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Recipient's Name]

[Recipient's Title]

[Facility/Hospital Name]

[Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request a copy of my medical history for the purpose of obtaining a second opinion regarding my diagnosis and treatment options for [specific condition].

My details are as follows:

- Full Name: [Your Full Name]
- Date of Birth: [Your Date of Birth]
- Patient ID (if applicable): [Your Patient ID]

Please include any relevant medical records, test results, and notes from my appointments that you may have on file. I understand that there may be certain procedures or fees associated with this request, and I am willing to comply with your requirements.

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

Sincerely,

[Your Name]