

[Your name]

[Your address]

[Your phone number]

[Date]

[Doctor's or Clinic's Name]

[Address]

Dear _____,

I am writing to request copies of my medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations.

I was treated at your clinic from [date] to [date]. Please include all charts, test results, consultation notes and referrals regarding my medical care during this period. Please mail the requested records to me at the above address.

I understand I may be charged a reasonable fee for copying the records, but that I will not be charged for the time spent locating the records. I also understand that I will be charged for postage.

Thank you for your cooperation. Please let me know if you need any additional information.

Sincerely,

[Your signature]

[Your name printed]