Your Name

Street Address

City, ST ZIP Code

Date

Doctor Name

Medical Practice or Hospital Name

Street Address

City, ST ZIP Code

|  |  |
| --- | --- |
| RE: | Release of medical records for Your nameDOB: date, SSN: Social Security Number |

Dear Doctor Name:

On date I sent you a written request asking for copies of my medical records related to treatment for medical conditions rendered by you or under your supervision from date through date. Since then, number days have passed and I have not yet received these records.

I am hereby making a second request that you send me these records immediately. I remind you that under the laws of this state, Statute # number, you are legally obligated to provide copies of my medical records upon my request.

If I have not received the records by date, I will have no choice but to retain an attorney to obtain my medical records for me. By law, you will then be liable for the attorney fees that I incur. I trust that this step will not be necessary.

Please mail the information to:

Your Name or Name of Party to Receive Records

Street Address

City, ST ZIP Code

As noted in my first request, I will be glad to pay for costs associated with providing me copies of my records

Sincerely,

Your Name