[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Recipient Name]
[Title (if applicable)]
[Medical Facility Name]
[Facility Address]
[City, State, Zip Code]

Dear [Recipient Name],

I am writing to formally request access to my medical records as permitted under the Health Insurance Portability and Accountability Act (HIPAA). 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 provide copies of all medical records related to my treatment from [Start Date] to [End Date]. If there are any forms or identification required to process this request, please let me know. I am happy to comply with any necessary procedures to facilitate this request.

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

Sincerely,

[Your Signature (if sending a hard copy)]
[Your Printed Name]