

[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]

[Recipient Name]
[Recipient Title]
[Healthcare Provider or Facility Name]
[Address]
[City, State, Zip Code]

Dear [Recipient Name],

I am writing to formally request a copy of my health records as permitted under the Health Insurance Portability and Accountability Act (HIPAA).

****Patient Information:****

- Full Name: [Your Full Name]
- Date of Birth: [Your Date of Birth]
- Address: [Your Address]
- Medical Record Number (if applicable): [Your Medical Record Number]

I would like to request the following medical records:

- [Specify the documents you are requesting, e.g., complete medical history, lab results, radiology reports, etc.]

Please let me know if you require any further information or documentation to process this request. I would appreciate it if you could fulfill this request within the 30-day timeframe set by HIPAA guidelines. Thank you for your attention to this matter.

Sincerely,

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