[Your Name]
[Your Address]
[City, State, ZIP Code]
[Email Address]
[Phone Number]
[Date]
[Recipient's Name]
[Medical Facility's Name]
[Facility's Address]
[City, State, ZIP Code]

Dear [Recipient's Name],

I am writing to request a copy of my medical records as permitted under the Health Insurance Portability and Accountability Act (HIPAA). My details are as follows:

- Name: [Your Full Name]
- Date of Birth: [Your Date of Birth]
- Patient ID (if applicable): [Your Patient ID]
- Dates of Treatment: [Specify the dates of service or treatment]

Please send my medical records to my address listed above or to my email address at [Your Email Address]. If there are any forms or identification required to process this request, please let me know.

Thank you for your assistance.

Sincerely,

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