[Your Healthcare Facility Letterhead]
[Date]
[Recipient Name]
[Recipient Address]
[City, State, Zip Code]

Dear [Recipient Name],

Subject: Release of Information

We are writing to inform you that we have received your request for the release of medical information pertaining to [Patient's Name], Date of Birth: [Patient's DOB].

Details of the requested records are as follows:

- Type of Records: [Specify type of records, e.g., medical notes, lab results]
- Date Range: [Specify dates, e.g., from MM/DD/YYYY to MM/DD/YYYY]

Please be advised that in accordance with the Health Insurance Portability and Accountability Act (HIPAA), we require written consent from the patient or their authorized representative to release this information.

Attached is a consent form for your completion. Once we receive the signed consent, we will process your request within [specify timeframe, e.g., 15 business days].

If you have any questions or require further assistance, please do not hesitate to contact our office at [Phone Number] or [Email Address].

Thank you for your understanding.

Sincerely,

[Your Name]
[Your Title]
[Your Healthcare Facility Name]
[Contact Information]