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

Dear [Recipient's Name],

Subject: Medical Records Request

I am writing to request a copy of my medical records related to my diagnosis and treatment of uveitis. Below are my details for your reference:

- Patient Name: [Your Full Name]
- Date of Birth: [Your DOB]
- Patient ID (if applicable): [Your ID]
- Dates of Treatment: [Date Range]

I would prefer to receive these records via [email/mail/fax] at the contact information listed above. If there are any forms or fees associated with this request, please let me know.

Thank you for your assistance in this matter.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]