Sample Request for Medical Records letter

Date_____
Provider Name_____
Medical Practice or Hospital Name_____
Street Address of Provider_____
City, State, ZIP of Provider_____

RE: Release of medical records for_____, DOB:_____

Dear Provider:

Please release my medical records related to treatment for obstetrics and gynecology issues rendered by you or under your supervision from 2007 through 2010. This information will be used to further assist in my medical care, and should be faxed to:

A Center for Women's Care, P.C.
Fax: 970-384-2211

or mailed to:

A Center for Women's Care, P.C.
2001 Blake Avenue, Suite 1A
Glenwood Springs, CO 81601

Sincerely,

Your Name_____

Your Address_____