

**RE:**

**Patient/Client:** \_\_\_\_\_  
**Date of Accident:** \_\_\_\_\_  
**Our File No:** \_\_\_\_\_

Dear \_\_\_\_\_:

I represent \_\_\_\_\_ in her claim for personal injuries arising out of an accident which occurred on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, at \_\_\_\_\_ in \_\_\_\_\_, \_\_\_\_\_. I am enclosing a medical authorization form signed by my client and request that you forward to me a comprehensive but concise narrative medical report that encompasses the following:

1. A description of the accident as related by my client combined with an opinion as to the reasonableness of the accident being the causative agent of the subsequent physical complaints;
2. A description of the Plaintiff's specific subject complaints;
3. The pertinent past medical history taken from my client and any probable or feasible association with the current complaints, and if applicable, address the matter of traumatic aggravation of any pre-existing conditions;
4. The pertinent subjective and objective physical findings, along with an opinion as to their significance, appropriateness, and relevancy;
5. The significance of the results of any diagnostic tests performed by you combined with an assessment of the consistency of these tests with the medical history and physical findings;

6. The probable diagnosis, combined with an expert opinion as to the consistency of the diagnosis with the accident in question and the balance of the medical information, and an opinion as to the degree of documentation of the diagnosis; and

7. A summarization of the treatment rendered.

Also, if appropriate, I would like for you to express an opinion as to the duration of any temporary total disability, temporary partial disability, and the expected date of maximum medical recovery with specific dates if sufficient medical information is available.

In addition, I would appreciate an opinion, based on the information you have available to you, and based on reasonable medical probabilities of the expected residual medical impairment of function/disability according to accepted guidelines. Please list the expected physical limitations resulting from the diagnosis and impairment/disability.

This office hereby revokes any and all prior medical authorizations issued by my client. No information concerning my client's medical condition should be provided to any person, other than a representative of this office, as all communication between physicians and patients is privileged under state and federal law.

No *ex parte* communication is permitted without specific authority from the patient. Privileged medical information shall not be communicated to or discussed with any persons other than this office except during a formal deposition and/or court appearance where at all times an attorney for my client is present.

Thank you for your cooperation. If you have any questions, please give me a call.

Sincerely,

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