

Laurel Yan
[Street Address]
[City, ST ZIP Code]
[Date]

[Doctor Name]
[Medical Practice or Hospital Name]
[Street Address]
[City, ST ZIP Code]

RE: Release of medical records for Laurel Yan, DOB: [date], SSN: [Social Security Number]

Dear [Doctor Name]:

Please release my medical records related to treatment for [medical conditions] rendered by you or under your supervision from [date] through [date]. This information will be used to further assist in my medical care, and should be mailed to:

[Your Name or Name of Party to Receive Records]
[Street Address]
[City, ST ZIP Code]

Please bill me for costs associated with providing copies of my records, and I will remit payment promptly upon receipt of the records.

Sincerely,

Laurel Yan