MYCHARTCOUNT

YOU ALREADY OWN IT

Records Request Letter Templates

Six ready-to-use templates for requesting your medical records from doctors, hospitals, insurers, pharmacies, and on behalf of family members. Each template cites the specific federal law that backs your request.

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TEMPLATE 01 · MYCHARTCOUNT GUIDE

Doctor / Clinic / Specialist

WHEN TO USE

Requesting your complete records from any individual doctor, clinic, or specialist's office where you've been seen.

[Your Full Legal Name]

[Your Street Address]

[City, State ZIP]

[Phone] · [Email]

[Today's Date]

[Doctor or Clinic Name]

Attn: Medical Records Coordinator / HIPAA Privacy Officer

[Clinic Address]

[City, State ZIP]

Re: Request for Access to Protected Health Information

Patient: [Your Full Legal Name]

Date of Birth: [Your DOB]

To Whom It May Concern,

Pursuant to my right of access under HIPAA (**45 CFR § 164.524) and the 21st** Century Cures Act information blocking rule (45 CFR Part 171), I am requesting a complete copy of all my Protected Health Information (PHI) maintained by your practice, including but not limited to:

- All clinical notes, progress notes, and consultation notes
- All laboratory results and pathology reports
- All imaging studies and radiology reports (reports AND image files in DICOM format)
- All medication and prescription records
- All referral letters and correspondence with other providers
- All billing and claims records

- All electronic health information (EHI) as defined under the Cures Act

Please provide these records in electronic format (PDF or via secure patient portal). I understand the following:

- Records must be provided within 30 days of this request (45 CFR § 164.524(b)(2)), and my state may require a shorter timeframe.
- You may charge only a reasonable, cost-based fee per HHS guidance. You may not charge for retrieval time or standard search. Records delivered electronically through the View, Download, and Transmit function of a Certified EHR must be provided at no cost.
- Under the Cures Act, you may not deny, delay, or materially interfere with my access to EHI.

Please send the records to: [Your preferred delivery: email / patient portal / mailing address]

For identity verification, I have attached a copy of my government-issued photo identification.

If you require additional verification or have questions about this request, please contact me at [phone] or [email].

If access is denied without a valid exception, delayed beyond the legal deadline, or if I am charged unreasonable fees, I reserve the right to file an information blocking complaint with the HHS Office of the National Coordinator (ONC) and a HIPAA complaint with the HHS Office for Civil Rights (OCR).

Sincerely,

_____

[Your Signature]

[Your Printed Name]

[Date]

TEMPLATE 02 · MYCHARTCOUNT GUIDE

Hospital (Full Record Set)

WHEN TO USE

Requesting records from a hospital. Hospital records are typically held by the Health Information Management (HIM) Department and span multiple categories: inpatient admissions, emergency department visits, imaging studies, lab work, and billing — all of which need to be requested explicitly.

[Your Full Legal Name]

[Your Street Address]

[City, State ZIP]

[Phone] · [Email]

[Today's Date]

[Hospital Name]

Health Information Management Department

[Hospital Address]

[City, State ZIP]

Re: Request for Complete Hospital Record Set

Patient: [Your Full Legal Name]

Date of Birth: [Your DOB]

Medical Record Number (if known): [MRN]

Dates of Service: [date range or "all encounters"]

To Whom It May Concern,

Under my right of access in HIPAA (**45 CFR § 164.524) and the 21st** Century Cures Act (45 CFR Part 171), I am requesting a complete copy of all my Protected Health Information held by [Hospital Name], including all departments and care settings.

Please include, at minimum, the following categories. I am requesting ALL of the following, not a summary of any of them:

INPATIENT / ADMISSION RECORDS

- All admission notes, history & physicals (H&P)
- All daily progress notes and consultation notes
- All discharge summaries
- All operative reports and procedure notes
- All nursing notes and care plans

EMERGENCY DEPARTMENT RECORDS

- All ED physician notes and triage notes
- All ED orders and results
- All discharge instructions

DIAGNOSTIC RECORDS

- All laboratory results (with actual values, not summaries)
- All pathology reports
- All cardiology and EKG/ECG reports
- All imaging reports AND the imaging studies in DICOM format (X-ray, CT, MRI, ultrasound, nuclear medicine, etc.)

MEDICATION RECORDS

- All medication administration records (MAR)
- All discharge medication lists and prescriptions

BILLING AND ADMINISTRATIVE

- All itemized billing records and UB-04 claim forms
- All insurance correspondence

PSYCHIATRIC / BEHAVIORAL HEALTH (if applicable) Please note: I am requesting access to my full record. Where psychotherapy notes are involved and are subject to separate HIPAA treatment, please indicate this in your response.

Please provide these records electronically. Acceptable formats are PDF (for narrative records), DICOM (for imaging), and either direct portal upload or email to [your email]. I do not request a CD-ROM as my computer cannot read it.

Under HIPAA, you have 30 days from receipt of this request to provide the records or to respond in writing with a permissible exception. HHS guidance prohibits charging fees for retrieval or search, and prohibits any fee for records delivered through a Certified EHR's View, Download, and Transmit function.

For identity verification, I have attached a copy of my government-issued photo identification.

If you require additional verification or wish to clarify scope, please contact me at [phone] or [email].

Sincerely,

_____

[Your Signature]

[Your Printed Name]

[Date]

TEMPLATE 03 · MYCHARTCOUNT GUIDE

Insurance Company / Health Plan

WHEN TO USE

Requesting your records from an insurance company or health plan. Insurance claims data often provides the most complete reconstruction of where you've received care over time — even when you can no longer remember every provider's name.

[Your Full Legal Name]

[Your Street Address]

[City, State ZIP]

[Phone] · [Email]

[Today's Date]

[Insurance Company Name]

Attn: Member Records / HIPAA Privacy Officer

[Insurance Company Address]

[City, State ZIP]

Re: Request for Complete Member Records and Claims Data

Member: [Your Full Legal Name]

Date of Birth: [Your DOB]

Member ID Number: [your member/policy number]

Coverage Dates: [date range or "all years covered"]

To Whom It May Concern,

Under my right of access in HIPAA (**45 CFR § 164.524)**, which applies to health plans as well as healthcare providers, I am requesting a complete copy of all Protected Health Information your organization maintains about me, including:

- All claims data (paid, denied, pending) with dates of service, provider names, CPT/HCPCS codes, ICD diagnosis codes, and amounts paid
- All prior authorization requests and decisions

- All correspondence with me and with providers
- All explanations of benefits (EOBs)
- All medical review notes and determinations
- All appeals and grievance records
- Any case management or care coordination records
- All eligibility and enrollment records

Please provide records in electronic format. Acceptable deliveries are PDF via email to [your email], or via your secure member portal.

Under HIPAA (**45 CFR § 164.524(b)(2)**), you have 30 days from receipt to provide the records or a written response. You may charge only a reasonable, cost-based fee per HHS guidance.

For identity verification, I have attached a copy of my government-issued photo identification and a copy of my insurance member card.

If you require additional verification or have questions about the scope of this request, please contact me at [phone] or [email].

Sincerely,

_____

[Your Signature]

[Your Printed Name]

[Date]

TEMPLATE 04 · MYCHARTCOUNT GUIDE

Pharmacy (Medication Fill History)

WHEN TO USE

Requesting your complete medication fill history from a pharmacy. Pharmacy records are usually the most accurate record of what medications you have actually taken — more complete than what's in any single doctor's office.

[Your Full Legal Name]

[Your Street Address]

[City, State ZIP]

[Phone] · [Email]

[Today's Date]

[Pharmacy Name and Chain]

Attn: Pharmacy Manager / HIPAA Privacy Officer

[Pharmacy Address]

[City, State ZIP]

Re: Request for Complete Prescription Fill History

Patient: [Your Full Legal Name]

Date of Birth: [Your DOB]

Patient ID / Loyalty Card Number (if any): [number]

To Whom It May Concern,

Under my right of access in HIPAA (**45 CFR § 164.524)**, I am requesting a complete copy of my prescription fill history from your pharmacy, including (if available across the entire chain or only at this location, please indicate):

- All prescriptions filled, with dates, drug names, strengths, dosage forms, quantities, days' supply, and prescribers
- All refill records
- All immunizations administered at the pharmacy

- All medication therapy management (MTM) records
- All counseling notes and pharmacist consultations
- All insurance claims submitted on my behalf

If your records system can produce a printout covering ALL of my fills from your chain (not just this single location), please do so. If your system only covers this single location, please indicate that limitation in your response.

Please provide the records electronically as a PDF to my email at [your email].

Under HIPAA, you have 30 days to respond. You may charge only a reasonable, cost-based fee per HHS guidance.

For identity verification, I have attached a copy of my government-issued photo identification.

If you require additional verification, please contact me at [phone] or [email].

Sincerely,

_____

[Your Signature]

[Your Printed Name]

[Date]

TEMPLATE 05 · MYCHARTCOUNT GUIDE

Personal Representative (Family Member)

WHEN TO USE

Requesting records on behalf of a family member. A parent requesting a minor child's records. An adult child requesting an aging parent's records (with written authorization). A spouse requesting a spouse's records. A court-appointed guardian. HIPAA recognizes "personal representatives" with the same access rights as the patient.

IMPORTANT: You will need to attach proof of your authority as personal representative. The proof depends on the relationship: parent of a minor (birth certificate); power of attorney for healthcare (signed POA document); court-appointed guardian (court order); executor of an estate (letters testamentary); spouse acting under a HIPAA authorization (signed form).

[Your Full Legal Name]

[Your Street Address]

[City, State ZIP]

[Phone] · [Email]

[Today's Date]

[Provider, Hospital, Insurer, or Pharmacy Name]

Attn: Medical Records / HIPAA Privacy Officer

[Their Address]

[City, State ZIP]

Re: Personal Representative Request for Access to Protected Health Information

Patient: [Patient's Full Legal Name]

Patient's Date of Birth: [Patient's DOB]

Personal Representative: [Your Full Legal Name]

Relationship to Patient: [parent / spouse / adult child / guardian / executor / etc.]

To Whom It May Concern,

I am the legally authorized personal representative of [Patient's Full Legal Name], and I am requesting access to the patient's Protected Health Information (PHI) under my right of access in HIPAA (**45 CFR § 164.502(g) and 45** CFR § 164.524) and the **21st Century Cures Act** (45 CFR Part 171).

Attached to this request is documentation establishing my authority as personal representative:

- ■ Birth certificate (parent of minor)
- ■ Healthcare power of attorney
- ■ Court-appointed guardianship order
- ■ Letters testamentary (executor of estate)
- ■ HIPAA authorization signed by patient
- ■ Other: [describe]

I am requesting a complete copy of all of the patient's PHI maintained by your organization, including:

- • All clinical notes, lab results, imaging reports and DICOM image files, medication records, and billing records
- • All electronic health information (EHI) as defined under the Cures Act

Please provide the records electronically to my email at [your email], or via secure portal access.

Under HIPAA, a personal representative must be treated as if they were the individual themselves for purposes of access to PHI (**45 CFR § 164.502(g)).** You have 30 days from receipt to provide the records or respond in writing.

For my identity verification, I have attached a copy of my government-issued photo identification.

If you require additional documentation or verification, please contact me at [phone] or [email].

Sincerely,

_____

[Your Signature]

[Your Printed Name]

[Date]

TEMPLATE 06 · MYCHARTCOUNT GUIDE

Follow-Up (Deadline Missed)

WHEN TO USE

When more than 30 days have passed since your original request and you have not received your records (or received only partial records, or received an inappropriate denial). This letter is the formal notice that you intend to escalate.

This letter alone often resolves the issue — most provider compliance offices know what comes next (an OCR complaint), and fix the issue immediately to avoid it.

[Your Full Legal Name]

[Your Street Address]

[City, State ZIP]

[Phone] · [Email]

[Today's Date]

[Provider, Hospital, Insurer, or Pharmacy Name]

Attn: HIPAA Privacy Officer / Compliance Officer

[Their Address]

[City, State ZIP]

Re: SECOND NOTICE — Failure to Respond to Access Request

Original Request Date: [date you sent the first letter]

Patient: [Your Full Legal Name]

Date of Birth: [Your DOB]

To Whom It May Concern,

On [original request date], I submitted a written request for access to my Protected Health Information under HIPAA's Right of Access (**45 CFR § 164.524) and the 21st** Century Cures Act (45 CFR Part 171). A copy of that original request is attached.

As of today's date, [today's date], more than 30 days have passed and:

- ■ I have received no response at all.
- ■ I have received only partial records.
- ■ I have been quoted unreasonable fees that violate HHS guidance on cost-based fees.
- ■ I have been required to use a process that creates unreasonable barriers to my access.
- ■ I have been denied access without a written explanation citing a specific HIPAA exception.

This response is not compliant with federal law. Specifically:

- • HIPAA (45 CFR § 164.524(b)(2)) requires that I receive my records within 30 days of the original request.
- • HHS guidance is explicit that providers may not charge for retrieval time or standard search, and may charge no fee at all for records delivered through a Certified EHR.
- • The 21st Century Cures Act information blocking rule (45 CFR Part 171) prohibits any practice that interferes with my access to my electronic health information.
- • Failure to comply may constitute "information blocking" subject to enforcement by the HHS Office of the National Coordinator (ONC) and a violation of HIPAA subject to enforcement by the HHS Office for Civil Rights (OCR).

I am giving you 14 days from the date of this letter to:

1. Provide the complete records I originally requested, in the electronic format I specified, AND 2. Provide a written explanation, if any fees are charged, of how those fees comply with **45 CFR § 164.524(c)(4) and** HHS guidance.

If I have not received a satisfactory response by [date 14 days from today], I will file the following complaints:

- • HHS Office for Civil Rights (OCR) HIPAA Right of Access complaint: https://www.hhs.gov/hipaa/filing-a-complaint/
- • HHS Office of the National Coordinator (ONC) Information Blocking complaint: https://inquiry.healthit.gov/
- • [State attorney general consumer protection division, if applicable in your state]
- • [State medical board, if applicable]

OCR has announced 54 enforcement actions under its Right of Access Initiative since 2019, with penalties from $16,500 to over $200,000. I would prefer this matter be resolved without escalation.

Please respond to me at [phone] or [email].

Sincerely,

_____

[Your Signature]

[Your Printed Name]

[Date]