[Your firm name and logo]

[Your name or firm name]
[Street address, city, NY ZIP] | [Phone] | [Email]
[Date]
To: Health Information Management / Release of Information
[Hospital or practice name]
[Records address]
Re: Records request for [Patient full name], date of birth [MM/DD/YYYY]

Dear Records Custodian,

Enclosure
Enclosed is OCA Official Form No. 960, signed by [the patient / the patient's representative, whose authority is stated in Items 12 and 13] on [date of signature].

Records requested
Please release the records described in Item 9(a): [the entire medical record / records from (start date) to (end date)], including [itemized billing / imaging reports / films on disc]. Psychotherapy notes are not requested.

Special categories
The patient has initialed Item 9(a) for: [alcohol or drug treatment / mental health information / HIV-related information]. Please include only the categories initialed. If your program needs its own 42 CFR Part 2 consent for substance use records, please tell us. SUD counseling notes are not requested.

HIV-related information (optional)
If your facility requires form DOH-2557 for HIV-related information, please tell us and we will send it signed.

Discussion with counsel (optional)
Item 9(b) is initialed, authorizing [Provider name] to discuss the patient's health information with [Attorney or agency name]. Please share a direct number for that conversation.

Format and fees
We prefer [paper copies / an electronic copy]. Please send an invoice before release if the fee exceeds $[amount]. If this request is for a government benefit claim, please note it on your invoice.

Contact
Questions about this request can go to [Name] at [phone] or [email]. Please quote our reference [file or matter number].

Sincerely,

_____
[Name]
[Title]
Enclosure: OCA Official Form No. 960