## Your Name

## Your Address  Your City  Your State & Zip  Your Telephone Number  Your Email

**Request for Medical Records**

**(sample)**

[DATE]

[DOCTOR OR FACILITY NAME]

[ADDRESS]

[CITY, STATE ZIP]

To Whom It May Concern:

This letter is to make a request for my medical records at no charge. These medical records are needed to support my appeal regarding eligibility for social security disability benefits for which I have an upcoming hearing. I am including proof of this disability appeal

This request is made in accordance with the [STATE] Medical Records law giving me a free copy of my medical records when the request is related to a disability claim.

I am requesting all health records from [DEPARTMENT/OFFICE] from [START DATE] through [END DATE]. These records can be mailed to me at [NAME, ADDRESS], or I can pick them up at your office.

Thank you for your assistance in this matter,

Regards,

[YOUR SIGNATURE]

[YOUR NAME PRINTED]

Attachment: Evidence of Disability Claim