

[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[Physician or Medical Provider Name]
[Facility Name]
[Address]
[City, State, Zip Code]

RE: Request for Medical Hardship Documentation - [Patient Full Name]

Dear [Provider Name],

I am writing to formally request a letter or clinical documentation regarding my current medical condition and its impact on my daily life. I am currently applying for [mention purpose: e.g., a financial assistance program, workplace accommodation, or student loan deferment] based on medical hardship.

Please provide a signed letter on your official letterhead that includes the following information:

- Confirmation of my diagnosis and date of onset.
- The nature and frequency of my current treatment plan.
- A brief explanation of how this condition limits my ability to [mention specific need: e.g., work full-time, attend school, or meet financial obligations].
- The expected duration of these limitations.

Attached is a signed HIPAA release form authorizing the disclosure of this information for the purpose of this application. If there are any administrative fees associated with preparing this documentation, please let me know.

I would appreciate receiving this documentation by [Date]. Please let me know if you need any additional information from me to complete this request.

Thank you for your time and continued care.

Sincerely,

[Your Signature]

[Your Printed Name]
[Patient Date of Birth]