



*One Stiles Road, Suite 201  
Salem, NH 03079  
603-893-3563  
603-893-7784 Fax*

DATE

DOCTOR OFFICE  
NAME ADDRESS  
Attention: Medical Records

Re: CLIENT  
D.O.B.  
Request for Attending Physician Statement

To Whom It May Concern:

The above referenced patient has applied for a Life Insurance policy and indicated on the application that NAME OF PHYSICIAN is her physician. In order to be considered for coverage we will need to obtain a current attending physician's statement from DOCTOR on the health of PATIENT.

We will require all consultation notes, labs, and any other documentation, including the most recent check up. Enclosed is a copy of the signed agreement/authorization to obtain and disclose information. We will need to have all medical information sent to **ADDRESS**. Please provide this information at your earliest convenience.

Thank you for your prompt attention to this matter.

**IF POSSIBLE PLEASE FAX MEDICAL RECORDS TO: FAX NUMBER**

Sincerely,