[Practice/Clinic Name]
[Address]
[City, State, Zip]
[Phone]

Date: [Month Day, Year]

To Whom It May Concern:

This letter confirms that [Patient’s Full Name], DOB: [Patient's Date of Birth], is under my direct care at [Practice/Clinic Name] and was formally diagnosed with Multiple System Atrophy (MSA) in [Year of Diagnosis].

If you require any further information, please feel free to contact me directly.

Sincerely,
[Signature]
[Provider’s Full Name, Credentials]
[Provider’s Title]