Date: [Insert Date]

To: [Name of Healthcare Provider/Facility]
Address: [Provider Address]
City, State, Zip: [City, State, Zip]

RE: Patient Authorization for Release of Medical Records

Patient Name: [Your Full Name]
Date of Birth: [MM/DD/YYYY]
Social Security Number (Optional): [Last 4 Digits or Full SSN]
Patient Address: [Your Current Address]

To Whom It May Concern,

I hereby authorize [Name of Healthcare Provider/Facility] to release my protected health information and complete medical records to the organization listed below for the purpose of evaluating my eligibility for a Total and Permanent Disability (TPD) loan discharge.

Release Information To:
Organization: [Name of Loan Servicer or Department of Education]
Address: [Recipient Address]
Fax/Email: [Recipient Contact Info if applicable]

Information to be Released:

- Complete medical history and physical examinations.
- Diagnostic test results and laboratory reports.
- Physician notes and clinical assessments regarding my disability status.
- Treatments, medications, and prognosis.

Purpose of Disclosure: To provide supporting documentation for a loan discharge application based on total and permanent disability.

This authorization is valid for one year from the date of signature unless revoked by me in writing. I understand that I have the right to revoke this authorization at any time. I also understand that the information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Thank you for your prompt assistance in this matter.

Sincerely,

____
[Patient Signature]

[Print Name]