[Physician Name, MD/DO]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

To Whom It May Concern,

I, [Physician Full Name], am the attending physician for [Patient Full Name], born on [Patient Date of Birth].

I hereby authorize [Name of Recipient/Organization] to [Specific Action: e.g., release medical records / allow return to work / provide specialized treatment] regarding the aforementioned patient.

This authorization is valid from [Start Date] through [End Date]. Should you require further clinical verification, please contact my office directly.

Sincerely,

_____
(Signature of Physician)

[Physician Name, Printed]
[Medical License Number]
[NPI Number]