

Date: [Insert Date]

To: [Name of Medical Facility/Doctor]

Address: [Facility Address]

City, State, Zip: [City, State, Zip Code]

RE: Authorization for Release of Medical Records

Patient Information:

Name: [Patient Full Name]

Date of Birth: [MM/DD/YYYY]

Social Security Number (Optional): [XXX-XX-XXXX]

Phone Number: [Your Phone Number]

I, [Patient Full Name], hereby authorize [Name of Medical Facility] to release my medical records to the following individual or organization:

Recipient Name: [Name of Person or Company]

Recipient Address: [Recipient Address]

Recipient Fax/Email: [Fax Number or Email Address]

Information to be Released:

- All medical records
- Records for the following dates: [Insert Dates]
- Specific reports (Lab results, X-rays, Immunizations)
- Other: [Specify]

Purpose of Disclosure: [e.g., Personal use, Legal proceedings, Continuing care, Insurance claim]

This authorization is valid for [Number] days from the date of signing, or until [Specific Date]. I understand that I have the right to revoke this authorization in writing at any time.

Signature of Patient or Legal Guardian

Printed Name