

Date: [Date]

To: [Name of Clinic/Doctor]

Address: [Clinic Address]

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

Subject: Authorization to Release Electronic Health Records (EHR)

Patient Information:

Full Name: [Patient Full Name]

Date of Birth: [MM/DD/YYYY]

Patient ID/Account Number (if known): [Account Number]

I hereby authorize the release of my medical records to the following recipient:

Recipient Name: [Name of New Clinic/Provider]

Address: [Recipient Address]

Email/Fax: [Recipient Contact Info]

Records Requested:

- Complete Electronic Health Record (EHR)
- Lab Results and Diagnostic Imaging
- Immunization Records
- Progress Notes and Medication History
- Other: [Specify]

Purpose of Release: [e.g., Transfer of Care, Personal Use, Insurance]

This authorization is valid for [Number] months from the date of signature unless revoked in writing. I understand that I have the right to inspect or copy the health information to be used or disclosed.

Sincerely,

Signature of Patient or Legal Guardian

Printed Name: [Print Name]