

## Patient Authorization for Release of Chronic Illness Records

**Date:** [Insert Date]

**To:**

[Name of Medical Provider/Facility]

[Address]

[City, State, Zip Code]

**Patient Information:**

Name: [Full Legal Name]

Date of Birth: [MM/DD/YYYY]

Patient ID/Account Number: [Insert Number, if known]

I hereby authorize the release of my medical records specifically related to the management and treatment of my chronic illness(es), including but not limited to: [List specific conditions, e.g., Diabetes, Hypertension, MS].

**Information to be released:**

Complete medical file

Lab results and diagnostic imaging

Medication history and prescriptions

Specialist consultation notes

Other: [Specify]

**Release records to:**

Name: [Recipient Name/Organization]

Address: [Recipient Address]

Phone/Fax: [Recipient Contact Info]

**Purpose of Disclosure:**

Continued medical care

Insurance claim processing

Legal purposes

Personal use

This authorization is valid for [Insert Timeframe, e.g., 90 days] from the date of signing. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken.

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**Patient Signature**

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**Print Name**