

**Date:** [Insert Date]

**To:** [Name of Healthcare Provider/Clinic/Hospital]

**Department:** Medical Records / Health Information Management

**Address:** [Insert Provider Address]

**RE: AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

**Patient Name:** [Insert Full Name]

**Date of Birth:** [Insert Date of Birth]

**Patient SSN/ID Number:** [Insert ID Number]

**Policy Number:** [Insert Insurance Policy Number]

To Whom It May Concern,

I hereby authorize [Name of Healthcare Provider] to release my obstetric and gynecological medical records to my insurance company, [Name of Insurance Company], for the purpose of [Reason: e.g., processing a claim, underwriting, or continued coverage].

**Information to be released:**

- Complete Obstetric Records (including prenatal care and delivery summaries)
- Gynecological Exam Results and Clinical Notes
- Laboratory Reports and Pathology Results
- Imaging Reports (Ultrasounds, Mammograms, Pelvic Exams)
- Surgical Reports and Discharge Summaries
- Billing Records

**Specific Dates of Service:** From [Start Date] to [End Date/Present].

I understand that this authorization is voluntary. I understand that my records may contain sensitive information regarding reproductive health. I specifically authorize the release of these records to ensure the processing of my insurance requirements.

This authorization shall remain valid for [Number] months from the date of signature, or until [Specific Expiration Date]. 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.

Please send the requested documents to:

[Name of Insurance Company]

[Department, e.g., Claims Department]

[Mailing Address]

[Fax Number/Email if applicable]

Sincerely,

---

(Signature of Patient or Legal Representative)

**Printed Name:** [Insert Printed Name]

**Relationship to Patient:** [Self/Legal Guardian]