

Date: [Date]

To: [Medical Provider/Facility Name]

Address: [Facility Address]

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

RE: Authorization to Release Medical Records

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Patient Social Security Number: [Last 4 Digits/Optional]

Patient Address: [Patient Address]

To Whom It May Concern,

I hereby authorize [Medical Provider/Facility Name] to release my medical records to the following third party for the purpose of processing an insurance claim:

Name of Third Party: [Insurance Company or Law Firm Name]

Contact Person: [Name of Representative/Adjuster]

Claim Number: [Claim Number]

Address: [Recipient Address]

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

Records Requested:

Please provide all medical records, including but not limited to: clinical notes, diagnostic test results, lab reports, imaging records, discharge summaries, and billing statements related to treatment received from [Start Date] to [End Date/Present].

This authorization is valid for [Number] months from the date of signature. 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 in reliance on this authorization.

A photocopy or digital scan of this authorization shall be considered as valid as the original.

Sincerely,

[Patient Signature or Legal Representative Signature]

Printed Name: [Printed Name]

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