

Date: [Date]

To: [Name of Medical Provider/Facility]

Address: [Facility Address]

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

RE: AUTHORIZATION TO RELEASE MEDICAL RECORDS AND PROTECTED HEALTH INFORMATION

Patient Name: [Patient Full Name]

Date of Birth: [Date of Birth]

Social Security Number: [Last 4 Digits or Full SSN]

Dates of Service: [Range of Dates or "All Records"]

To Whom It May Concern,

I, [Patient Name], hereby authorize [Name of Medical Provider/Facility] to release my protected health information and medical records to my legal representatives listed below:

Law Firm Name: [Name of Law Firm]

Attorney Name: [Name of Attorney]

Address: [Firm Address]

Phone Number: [Firm Phone Number]

Email: [Firm Email Address]

This authorization includes, but is not limited to, the following information:

- Complete medical charts and office notes
- Diagnostic imaging reports (X-rays, MRI, CT scans)
- Laboratory and pathology results
- Billing and insurance statements
- Emergency room and hospitalization records
- Pharmacy and prescription records

Purpose of Disclosure: Legal representation and related litigation.

This authorization is 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 in reliance on it.

Please provide the requested records in [Electronic/Paper] format to the legal representative at the address provided above.

Sincerely,

[Patient or Legal Guardian Signature]

Print Name: [Patient or Guardian Name]

Relationship to Patient: [Self/Parent/Guardian]