

Date: [Insert Date]

To: [Name of Hospital/Clinic/Doctor]

Address: [Facility Address]

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

RE: AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: [Patient's Full Name]

Date of Birth: [Patient's Date of Birth]

Social Security Number (Optional): [Patient's SSN]

Patient Address: [Patient's Address]

To Whom It May Concern,

I, [Patient's Full Name], hereby authorize [Name of Hospital/Clinic] to release my medical records to my family member/caregiver named below:

Authorized Representative Name: [Caregiver's Full Name]

Relationship to Patient: [e.g., Daughter, Son, Spouse]

Caregiver Phone Number: [Caregiver's Phone Number]

Caregiver Address: [Caregiver's Address]

Information to be Released:

- ☐ Complete Medical Record
- ☐ Records for the following dates: [Insert Dates]
- ☐ Specific Reports (Lab results, Imaging, Progress notes)
- ☐ Other: [Specify]

Purpose of Disclosure: [e.g., Continuity of Care, Personal Use, Legal Matters]

This authorization is valid for [Number] months from the date of signature or until [Specific Date]. I understand that I have the right to revoke this authorization in writing at any time.

Please provide the records via: ☐ Pickup ☐ Mail to Caregiver's Address ☐ Secure Email:
[Caregiver's Email]

Sincerely,

Signature of Patient (or Legal Guardian)

Printed Name: [Patient or Guardian Name]

Date Signed: [Insert Date]