

[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Medical Provider Name]
[Facility Name]
[Provider Address]
[City, State, Zip Code]

RE: Authorization to Release Medical Records for Disability Claim

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Social Security Number: [Last 4 Digits or Full SSN]

To Whom It May Concern,

I am writing to formally authorize the release of my protected health information to my employer's designated third-party administrator regarding my current disability claim.

Authorized Third Party:

[Name of Third-Party Administrator/Insurance Company]
[Address]
[Contact Person/Department]
[Fax Number/Email]

Information to be Released:

Please provide all medical records related to my treatment from [Start Date] to [End Date/Present]. This includes, but is not limited to: physician notes, diagnostic test results, surgical reports, physical therapy records, and medication lists relevant to my functional limitations and ability to work.

Purpose of Disclosure:

This information is to be used for the sole purpose of evaluating and processing my application for disability benefits.

Expiration:

This authorization shall remain valid for one year from the date of signature or until the conclusion of my disability claim, whichever occurs first. I understand that I have the right to revoke this authorization in writing at any time.

Please forward the requested documents to the third party listed above via [Mail/Fax/Secure Portal].

Thank you for your prompt attention to this matter.

Sincerely,

[Signature of Patient or Legal Representative]

[Printed Name]

[Relationship to Patient, if applicable]