

Date: [Date]

To: [Name of Holding Doctor/Clinic]

Department: Medical Records

Address: [Clinic Address]

RE: AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: [Patient Full Name]

Date of Birth: [MM/DD/YYYY]

Patient SSN/ID: [Optional ID Number]

To Whom It May Concern,

I hereby authorize [Name of Holding Doctor/Clinic] to release my protected health information to the specialist listed below for the purpose of a medical referral and continued care.

Recipient Specialist: [Name of Specialist]

Facility Name: [Name of Specialist's Practice]

Address: [Specialist Office Address]

Phone/Fax: [Specialist Contact Info]

Information to be Released:

- Progress notes from the last 12 months
- Laboratory and diagnostic test results
- Radiology reports and imaging
- Current medication list and immunization records
- [Specify any other specific records here]

This authorization is valid for [Number] months from the date of signature. I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken.

Please deliver these records via [Mail / Secure Email / Fax]. If there are any fees associated with this request, please notify me in advance.

Sincerely,

[Patient or Legal Representative Signature]

Print Name: [Name]

Relationship to Patient: [Self/Parent/Guardian]