

Date: [Date]

TO: [Name of Medical Provider/Facility]

Address: [Provider Address]

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

RE: AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: [Patient Full Name]

Date of Birth: [Patient Date of Birth]

Social Security Number: [Patient SSN - Optional]

To Whom It May Concern,

I hereby authorize [Name of Medical Provider/Facility] to release my complete medical records to [Name of Insurance Company/Third-Party Agency] for the purpose of life insurance underwriting and risk assessment.

Information to be released:

- Complete medical history and clinical notes.
- Laboratory test results and diagnostic imaging reports.
- Prescription drug history.
- Consultation and discharge summaries.
- [Optional: Information regarding HIV/AIDS, mental health, or substance abuse treatment].

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 it.

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

Sincerely,

Signature of Patient or Legal Representative

Printed Name: [Print Name]

Relationship to Patient: [Self / Legal Guardian / Power of Attorney]