

Date: [Insert 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: [MM/DD/YYYY]

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

Claim/Case Number: [Insert Benefit Claim Number]

To Whom It May Concern,

I hereby authorize [Name of Medical Provider/Facility] to release my protected health information and complete medical records to the following government agency and/or their authorized representative:

Name of Agency/Representative: [Insert Agency Name, e.g., Social Security Administration / VA]

Address: [Agency Address]

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

Information to be Released:

This authorization includes all medical records, including but not limited to: office visit notes, diagnostic test results (X-rays, MRIs, blood work), surgical reports, hospitalizations, and treatment plans from the period of [Start Date] to [End Date/Present].

Purpose of Disclosure:

This information is to be used for the purpose of determining eligibility for [Insert Type of Benefit, e.g., Disability Benefits].

Expiration and Revocation:

This authorization will expire one year from the date of signature unless otherwise revoked by me in writing. I understand that I have the right to revoke this authorization at any time by notifying the medical provider in writing.

Please provide these records as soon as possible to ensure the timely processing of my benefit claim.

Sincerely,

[Patient Signature]

[Legal Representative Signature, if applicable]

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