

[Your Name/Organization Name]

[Your Address]

[City, State, Zip Code]

[Phone Number]

[Date]

[Facility Name]

[Health Information Management/Medical Records Department]

[Facility Address]

[City, State, Zip Code]

RE: Authorization to Release Medical Records

Patient Name: [Patient Full Name]

Date of Birth: [MM/DD/YYYY]

Social Security Number (Last 4 digits): [XXXX]

Dates of Service: [From Date] to [To Date]

To Whom It May Concern,

Please accept this letter as formal authorization to release the medical records of the above-named patient to [Name of Third-Party/Receiving Facility].

I am requesting the following records:

- Discharge Summary
- History and Physical
- Progress Notes
- Medication Administration Records (MAR)
- Lab and Imaging Reports
- Care Plan and Minimum Data Set (MDS)
- [Specify any other records]

The purpose of this request is for [Reason: e.g., Continuing Care, Legal Matter, Personal Records].

Attached to this letter is a signed HIPAA-compliant Authorization for Release of Information form executed by the patient or their legally authorized representative.

Please deliver these records via [Method: e.g., Secure Email, Fax to (Number), or Mail to Address]. If there are any costs associated with this request, please notify me in advance.

Thank you for your prompt attention to this matter. If you have any questions, please contact me at [Your Phone Number].

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Relationship to Patient/Title]