[Your Full Name]
[Your Address]
[Your Phone Number]
[Date]

[Name of Releasing Facility/Doctor]
[Department, e.g., Radiology/Records]
[Address of Releasing Facility]

RE: Authorization to Release Diagnostic Records

To Whom It May Concern,

I, [Your Full Name], date of birth [Your DOB], hereby authorize [Name of Releasing Facility] to release and forward copies of my diagnostic records to the surgical specialist listed below.

Recipient Information:
Name of Specialist: [Specialist's Name]
Clinic/Hospital Name: [Clinic Name]
Address: [Full Address]
Fax/Email (if applicable): [Fax Number or Secure Email]

Records to be Forwarded:
Please include the following diagnostic materials from [Date Range or Specific Visit]:
- Imaging reports (MRI, CT, X-Ray, etc.)
- Original imaging files (DICOM/CD if requested)
- Pathology reports
- Laboratory results

This authorization is valid for 90 days from the date of signature and is specifically for the purpose of surgical consultation and treatment planning. I understand that I may revoke this authorization in writing at any time.

Thank you for your prompt attention to this request.

Sincerely,

_____
[Your Signature]

[Your Printed Name]
[Your Social Security Number or Patient ID, if required]