Date: [Date]

To: [Doctor or Hospital Name]
Address: [Facility Address]
City, State, Zip: [City, State, Zip]

RE: Authorization for Release of Medical Records

Patient Name: [Full Name]
Date of Birth: [Date of Birth]
Social Security Number: [SSN - Optional/As Required]

To Whom It May Concern,

I hereby authorize the release of my complete medical records to **[Insurance Company Name]** for the purpose of underwriting an application for life insurance.

Please provide copies of all records, including but not limited to:

- Physician notes and consultation reports
- Laboratory test results and pathology reports
- Diagnostic imaging reports (X-rays, MRIs, CT scans)
- Prescription medication history
- Hospitalization and surgical records

This authorization includes information regarding treatment for physical and mental illness, alcohol or drug abuse, and HIV/AIDS status, unless otherwise restricted by state law.

A photocopy or digital scan of this signed authorization shall be considered as valid as the original. This authorization is valid for 24 months from the date of signature unless revoked by me in writing.

Please send the requested information to:

[Insurance Company Name]
[Underwriting Department Address]
[City, State, Zip]
[Fax Number/Email if applicable]

Sincerely,

_____
[Patient Signature]

[Date Signed]