[Your Name]
[Your Address]
[Your City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[Insurance Company Name]
[Claims Department Address]
[City, State, Zip Code]

RE: Medical Records Authorization for Claim #[Claim Number]

To Whom It May Concern,

I, [Your Full Name], hereby authorize [Name of Healthcare Provider/Hospital] to release my medical records to [Name of Insurance Company] for the purpose of processing health insurance claim #[Claim Number] regarding services provided on [Date of Service].

The information to be disclosed includes:

- Physician notes and consultation reports
- Diagnostic test results (X-rays, blood work, MRI, etc.)
- Discharge summaries
- Itemized billing statements

This authorization is valid specifically for the claim mentioned above and shall expire on [Expiration Date or "upon final settlement of this claim"]. 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.

Please contact me at [Your Phone Number] if further information is required to expedite this request.

Sincerely,

_____
[Your Signature]

[Your Printed Name]
[Date of Birth]
[Policy/Member ID Number]