Date: [Date]

To: [Name of Medical Provider/Facility]
Address: [Street Address]
City, State, Zip: [City, State, Zip Code]

RE: AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Social Security Number: [SSN - Optional]
Date of Incident: [Date of Auto Accident]

To Whom It May Concern,

I hereby authorize [Name of Medical Provider/Facility] to release my protected health information and complete medical records to:

Recipient Name: [Name of Insurance Company or Attorney]
Address: [Recipient Street Address]
City, State, Zip: [City, State, Zip Code]

This authorization applies to all records related to injuries sustained in the automobile accident occurring on the date listed above, including but not limited to:

- Physician notes and evaluations
- Diagnostic imaging reports (X-ray, MRI, CT scans)
- Laboratory test results
- Emergency room and hospital records
- Physical therapy and rehabilitation records
- Itemized billing statements

The purpose of this disclosure is for the evaluation and settlement of a bodily injury claim resulting from an auto accident.

This authorization is valid for [Number] months from the date of signature unless revoked by me in writing. A photocopy or electronic copy of this authorization shall be considered as valid as the original.

Sincerely,

_____
[Patient Signature]

_____

[Printed Name]