Date: [Date]

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

RE: AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Social Security Number: [SSN (Optional/Last 4)]
Patient Address: [Patient Address]

To Whom It May Concern:

I hereby authorize [Name of Medical Provider/Facility] to release my protected health information and complete medical records to [Name of Recipient/Insurance Company/Attorney].

Information to be Released:
The information to be disclosed should include, but is not limited to:

- Office notes and clinical summaries
- Diagnostic imaging reports (X-rays, MRIs, CT scans)
- Laboratory and pathology results
- Surgical and hospital records
- Treatment plans and physical therapy notes
- Mental health records (if applicable)

Purpose of Disclosure:
This information is being requested for the purpose of a disability claim evaluation and related legal/administrative proceedings.

Duration:
This authorization shall remain valid for [Number] months from the date of signature, unless revoked by me in writing at an earlier date.

Rights:
I understand that I have the right to revoke this authorization at any time. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Signature: _____
Date: _____

Relationship to Patient: [Self / Legal Representative]