Date: [Date]

To: [Name of Facility/Provider]
Address: [Facility Address]

Subject: Authorization for Release of Medical Records for a Minor

To Whom It May Concern,

I, [Your Full Name], am the [Parent/Legal Guardian] of the minor child listed below:

- **Child's Full Name:** [Child's Name]
- **Date of Birth:** [Child's Date of Birth]
- **Patient ID/Account Number (if known):** [ID Number]

I hereby authorize [Name of Facility/Provider] to release the medical records of the aforementioned minor to:

Recipient Name: [Name of Person or Organization]
Recipient Address: [Recipient Address]
Recipient Phone/Fax: [Recipient Contact Info]

Information to be released:

[ ] All medical records
[ ] Records for the period of [Date] to [Date]
[ ] Specific records only (e.g., Immunization records, Lab results): [Specify]

Purpose of Disclosure: [e.g., Personal use, School enrollment, Transfer of care]

This authorization is valid until [Date or Event] or until revoked by me in writing. I understand that I have the right to revoke this authorization at any time.

Sincerely,

_____
Signature of Parent/Legal Guardian

Print Name: [Your Full Name]
Phone Number: [Your Phone Number]