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

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

RE: Authorization for Release of Medical Records for Appeal
Patient Name: [Patient Full Name]
Policy Number: [Policy Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]

To Whom It May Concern,

I am writing to formally authorize the release of my medical records to [Insurance Company Name] specifically for the purpose of reviewing the appeal for the denied claim referenced above.

I hereby authorize [Name of Healthcare Provider/Hospital] to release any and all medical records, including but not limited to, diagnostic test results, physician notes, treatment plans, and discharge summaries related to the services provided on [Date of Service].

This authorization is granted solely for the evaluation of my appeal and shall remain valid until the appeal process is completed or until I revoke it in writing.

Please include these records in my appeal file to ensure a comprehensive review of the medical necessity of the services provided.

Sincerely,

[Your Signature]
[Your Printed Name]