Date: [Date]

To: [Custodian of Records / Provider Name]
Facility: [Medical Facility Name]
Address: [Facility Address]

RE: AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: [Employee Full Name]
Date of Birth: [DOB]
Social Security Number: [Last 4 Digits]
Date of Injury: [Date]
Claim Number: [Claim Number]

To Whom It May Concern:

This letter serves as formal instruction and authorization to release any and all medical records, reports, and billing information in your possession pertaining to the treatment of the above-named individual regarding their Workers' Compensation claim.

Please provide the following:

- Complete medical history and clinical notes.
- Diagnostic imaging reports (X-rays, MRIs, CT scans).
- Physical therapy and rehabilitation progress notes.
- Itemized billing statements.
- Work status reports and restriction forms.

Please deliver these records to:

[Insurance Company or Law Firm Name]
[Recipient Name/Department]
[Mailing Address]
[Email Address/Fax Number]

This authorization is valid for 12 months from the date of signature unless revoked in writing. A photocopy or electronic scan of this signed letter shall be considered as valid as the original.

Sincerely,

_____
[Employee Signature]

_____
[Printed Name]