**Date:** [Insert Date]

**To:** Medical Records Department / Health Information Management
**Hospital Name:** [Insert Hospital Name]
**Address:** [Insert Hospital Address]

**RE: Authorization and Instruction for Release of Discharge Summary**

**Patient Name:** [Insert Full Name]
**Date of Birth:** [Insert Date of Birth]
**Patient ID/Medical Record Number (if known):** [Insert ID Number]
**Date of Admission:** [Insert Date]
**Date of Discharge:** [Insert Date]

Dear Medical Records Manager,

I am writing to formally request and authorize the release of my **Discharge Summary** regarding the hospital stay listed above.

Please deliver the requested documentation to the following recipient:

**Recipient Name/Organization:** [Insert Name of Doctor or Clinic]
**Address:** [Insert Full Mailing Address]
**Fax Number (if applicable):** [Insert Fax Number]
**Email (if applicable):** [Insert Email Address]

This information is required for the purpose of: [Insert Reason, e.g., Continuity of Care / Personal Records].

This authorization is valid for 90 days from the date of signature unless revoked by me in writing. A photocopy or scan of this letter shall be considered as valid as the original.

Please contact me at [Insert Phone Number] if there are any forms to complete or fees associated with this request.

Sincerely,

_____
**[Insert Patient Name or Legal Representative]**