

Medical record release authorization

Subject: Authorization to Release Medical Records

Dear [Medical Facility Name],

I, [Patient Name], authorize [Medical Facility] to release my medical records including diagnosis, treatment, and test results to [Recipient Name or Institution].

This authorization covers records from [Start Date] to [End Date] and is valid until [Expiry Date].

I understand that this information is confidential and will only be used for [purpose].

Thank you,

[Patient Name]

[Contact Information]

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