Sample Authorization to Release Medical Records

[Your Name]

[Your Address]

[City, State, ZIP Code]

[Date]

To Whom It May Concern,

I, [Your Name], hereby authorize [Healthcare Provider's Name] to release my medical records and information to [Recipient's Name and Address], for the purpose of [Specify the purpose, e.g., medical consultation, insurance claim, legal matter].

This authorization includes all medical records, test results, diagnoses, and treatment information related to my health. I grant permission for the release of this information as needed.

Please consider this letter as my formal authorization for the release of my medical records.

Sincerely,

[Your Signature]

[Your Printed Name]