Authorization for Electronic Health Record Viewing

Date: __________

To Whom It May Concern,

I, [Your Full Name], born on [Your Date of Birth], hereby authorize [Recipient's Full Name/Title] to access and view my electronic health records.

This authorization is valid from [Start Date] to [End Date]. I understand that I may revoke this authorization at any time by providing written notice to [Provider's Name/Organization].

Thank you for your attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Contact Information]