Medical Records Release Form

Date: _____

To: [Healthcare Provider's Name]

[Provider's Address]

[City, State, Zip Code]

Dear [Healthcare Provider's Name],

I, [Your Name], born on [Your Date of Birth], hereby authorize the release of my medical records as detailed below:

Patient Information

Full Name: _____

Date of Birth: _____

Social Security Number: _____

Records to be Released

Please release the following information: [Specify type of records, e.g. complete medical records, specific treatment records, etc.]

Release To

This information should be released to: [Recipient's Name or Organization]

Address: _____

City, State, Zip Code: _____

This authorization is valid until [Expiration Date], and I understand that I have the right to revoke this authorization at any time.

Signature: _____

Date: _____

If you have any questions regarding this authorization, please contact me at [Your Phone Number] or [Your Email].

Thank you for your attention to this matter.

Sincerely,

[Your Printed Name]