Authorization Letter

Date: _____

To Whom It May Concern,

I, [Your Name], hereby authorize [Recipient's Name/Organization] to communicate and provide information regarding my medication and health conditions to my healthcare provider, [Healthcare Provider's Name], at [Healthcare Provider's Address].

This authorization is valid from [Start Date] to [End Date] unless revoked in writing.

Thank you for your cooperation.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Contact Information]