Medical Record Access Authorization

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], born on [Your Date of Birth], hereby authorize the release of my medical records to the following individual:

Name: [Authorized Person's Name]
Relationship: [Relationship to You]
Address: [Authorized Person's Address]
Phone Number: [Authorized Person's Phone Number]

This authorization is valid for the following information:

- Medical History
- Treatment Records
- Laboratory Results
- Imaging Reports
- Prescriptions

I understand that I have the right to revoke this authorization at any time, and that this authorization will expire one year from the date signed unless otherwise specified.

By signing below, I affirm that I have read and understand this authorization.

Signature: _____
Printed Name: [Your Name]
Date: _____
Contact Information: [Your Phone/Email]

Thank you for your attention to this matter.

Sincerely,
[Your Name]