Authorization to Obtain Medical Documents

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], hereby authorize [Recipient's Name/Organization's Name] to obtain my medical documents on my behalf. This authorization includes the right to access and retrieve my medical records from [Name of Medical Facility or Provider].

Details of Authorization:

- Patient Name: [Your Full Name]
- Date of Birth: [Your Date of Birth]
- Social Security Number: [Your SSN] (if necessary)
- Address: [Your Address]

This authorization is valid until [Expiration Date], unless revoked in writing before that time.

Thank you for your assistance.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]

[Your Contact Information]