Third-Party Authorization for Medical Records Release

Date: ____________

To Whom It May Concern,

I, [Your Name], hereby authorize [Healthcare Provider/Facility Name] to disclose my medical records to the following third-party:

Recipient's Name: [Recipient's Name]
Recipient's Address: [Recipient's Address]
Recipient's Phone Number: [Recipient's Phone Number]

This authorization is valid for the purpose of [specific purpose, e.g., legal matters, insurance claims, etc.], and will remain in effect until [expiration date, if applicable].

I understand that I have the right to revoke this authorization at any time by providing a written notice to [Healthcare Provider/Facility Name].

Thank you for your assistance.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Date of Birth]
[Your Contact Information]