

Authorization for Release of Confidential Information

Date: _____

To Whom It May Concern:

I, **[Your Name]**, residing at **[Your Address]**, hereby authorize **[Recipient's Name]** at **[Recipient's Address]** to release my confidential information, specifically **[Specify the type of information, e.g., medical records, financial records, etc.]**, to **[Authorized Person/Agency's Name]** at **[Authorized Person/Agency's Address]**.

This authorization is valid from **[Start Date]** to **[End Date]** and may be revoked by me at any time in writing. However, any information released under this authorization prior to revocation will remain valid.

By signing below, I acknowledge that I have read and understand this authorization and that I am signing it voluntarily.

Signature: _____

Printed Name: _____

Date: _____

Contact Information: **[Your Phone Number]**, **[Your Email]**

Thank you for your attention to this matter.