Authorization to Obtain Medical Records

Date: ____________________

To Whom It May Concern,

I, **[Your Full Name]**, born on **[Your Date of Birth]**, residing at **[Your Address]**, hereby authorize **[Recipient's Name or Organization]** to obtain my medical records from **[Hospital Name]**.

My details are as follows:

- Full Name: [Your Full Name]
- Date of Birth: [Your Date of Birth]
- Social Security Number: [Your SSN]
- Contact Number: [Your Phone Number]

Records requested include all medical documentation relevant to my treatment and history.

This authorization is valid until **[Expiration Date]**, unless revoked in writing.

Thank you for your assistance.

Sincerely,

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[Your Signature]

[Your Printed Name]