# Consent Form for Release of Medical Records

Date: _____

To Whom It May Concern,

I, **[Your Name]**, born on **[Date of Birth]**, residing at **[Your Address]**, hereby authorize **[Hospital Name]** to release my medical records to the following individual/organization:

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

Details of the records to be released:

- Complete medical history
- Diagnostic test results
- Treatment records
- Other: _____

This consent is valid from **[Start Date]** to **[End Date]**. I understand that I have the right to revoke this consent at any time by providing written notice.

Signature: _____

Date: _____