Authorization for Release of Medical Records

Date: [Insert Date]

To Whom It May Concern,

I, [Patient's Full Name], born on [Patient's Date of Birth], hereby authorize [Third Party Service Name] to access my medical records held by [Healthcare Provider's Name].

This authorization includes the release of all medical records and information pertaining to my health history, treatment, and any other pertinent details necessary for the purpose of [specific purpose, e.g., coordinating care, conducting insurance claims].

I understand that I have the right to revoke this authorization at any time by providing written notice to [Healthcare Provider's Name]. However, I acknowledge that any such revocation will not affect any actions taken prior to the receipt of the revocation.

This authorization is valid from [Start Date] until [End Date].

Thank you for your attention to this matter.

Sincerely,

[Patient's Signature]

[Patient's Printed Name]

[Patient's Address]

[Patient's Phone Number]

[Patient's Email Address]