Authorization for Medical Records Release

Date: _____

To Whom It May Concern,

I, **[Your Full Name]**, born on **[Your Date of Birth]**, and residing at **[Your Address]**, hereby authorize **[Name of the Healthcare Provider or Institution]** to release my medical records to:

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

The information to be released includes:

- Medical history
- Diagnosis
- Treatment records
- Test results

This authorization is valid until **[Expiration Date]**. I understand that I have the right to revoke this authorization at any time by providing a written notice to **[Healthcare Provider's Name]**.

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

Signature: _____

Print Name: **[Your Full Name]**

Date: _____