Patient Authorization for Record Sharing

Date: ____________

To Whom It May Concern,

I, **[Patient's Full Name]**, born on **[Date of Birth]**, hereby authorize the release of my medical records as detailed below to:

[Recipient's Name]
[Recipient's Organization]
[Recipient's Address]

This authorization applies to the following information:

- Medical history
- Treatment records
- Test results

This authorization is valid until **[Expiration Date]**.

I understand that my records are protected under federal and state privacy laws and that the information disclosed may be subject to re-disclosure. I request that the information be shared in the following format: **[Format]**.

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

Signature: ________________________

Printed Name: ____________________

Date: ____________________________