Medical Record Release Authorization for Continuity of Care

Date: [Insert Date]

To Whom It May Concern,

I, [Patient's Name], born on [Patient's Date of Birth], hereby authorize the release of my medical records to ensure continuity of care.

Patient Information:
Name: [Patient's Name]
Address: [Patient's Address]
Phone Number: [Patient's Phone Number]
Date of Birth: [Patient's Date of Birth]
Social Security Number: [Patient's SSN]

Recipient Information:
Name: [Recipient's Name]
Organization: [Recipient's Organization]
Address: [Recipient's Address]
Phone Number: [Recipient's Phone Number]

I authorize the release of my complete medical records, including but not limited to:
- History and physical examination reports
- Diagnosis and treatment information
- Laboratory and radiology reports
- Other relevant medical information

This authorization is valid until [Expiration Date] unless revoked by me in writing before this date.

Signature: _____
Printed Name: [Patient's Name]
Date: _____

If you have any questions, please contact me at [Patient's Phone Number] or [Patient's Email].

Thank you for your attention to this matter.

Sincerely,
[Patient's Name]