Medical Record Release Authorization

Date: _____

To Whom It May Concern,

I, **[Your Full Name]**, hereby authorize **[Healthcare Provider's Name]** to release my medical records for the purpose of employer verification. This authorization includes the release of any medical information necessary to evaluate my health status as it relates to my employment.

Employer Name: **[Employer's Name]**

Employer Address: **[Employer's Address]**

Employer Phone Number: **[Employer's Phone Number]**

This authorization is valid until **[Expiration Date]**, unless revoked in writing by me. I understand that I have the right to withdraw this authorization at any time.

Thank you for your attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Date of Birth]

[Your Contact Information]