Medical Record Release Authorization

Date: _____

To Whom It May Concern,

I, **[Your Full Name]**, hereby authorize the release of my medical records to my family member, **[Family Member's Full Name]**, who resides at **[Family Member's Address]**.

This authorization includes access to all medical records, including but not limited to, health history, lab results, treatment plans, and any other relevant medical information.

Please release this information to the designated family member not later than **[Specify Date]**.

I understand that I have the right to revoke this authorization at any time, and that revocation must be in writing. This authorization will expire on **[Expiry Date]**.

Thank you for your attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Contact Information]