Medical Record Release Authorization

Date: ____________________

To: [Healthcare Provider's Name]

[Healthcare Provider's Address]

[City, State, Zip Code]

From: [Patient's Name]

[Patient's Address]

[City, State, Zip Code]

[Patient's Date of Birth]

Subject: Authorization to Release Medical Records

I, [Patient's Name], hereby authorize [Healthcare Provider's Name] to release my medical records to the following individual or entity:

[Recipient's Name]

[Recipient's Address]

[City, State, Zip Code]

The specific medical records to be disclosed are as follows:

- All medical records
- Specific dates of treatment: [Date Range]
- Other specific records: [Details]

This authorization is valid from [Start Date] to [End Date]. I understand that I have the right to revoke this authorization at any time by providing a written notice. I acknowledge that the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected under federal or state law.

Signature: __________________________

Print Name: ________________________

Date: ____________________