Medical Record Release Authorization

Patient Name: [Patient's Full Name]

Date of Birth: [Patient's Date of Birth]

Address: [Patient's Address]

Contact Number: [Patient's Contact Number]

Recipient: [Insurance Company Name]

Address: [Insurance Company Address]

Contact Number: [Insurance Company Contact Number]

I, [Patient's Full Name], hereby authorize the release of my medical records to the above-named insurance company for the purpose of [specific purpose, e.g. claim processing, benefits determination].

Details of the information to be released include:

- Medical history
- Treatment records
- Diagnostic results
- Other relevant information

This authorization is valid until [expiration date or event]. I understand that I may revoke this authorization at any time by providing written notice to [Provider's Name], however, it will not apply to information already released.

Signature: _____

Date: _____