Medical Record Release Authorization

Date: [Insert Date]

To: [Recipient's Name]
[Recipient's Address]
[City, State, Zip Code]

Re: Authorization for Release of Medical Records

Dear [Recipient's Name],

I, [Your Full Name], born on [Your Date of Birth], authorize the release of my medical records to:

[Attorney's Name]
[Attorney's Firm Name]
[Attorney's Address]
[City, State, Zip Code]

This authorization pertains to the following records:

- All medical records pertaining to my treatment from [Start Date] to [End Date].
- Any other medical documents necessary for the legal matter related to [Brief Description of Legal Matter].

I understand that these records are confidential and will only be used for the purpose stated above. I also understand that I have the right to revoke this authorization at any time by providing written notice.

This authorization is valid until [Expiration Date], unless revoked earlier.

Thank you for your attention to this matter.

Sincerely,
[Your Signature (if sending a hard copy)]
[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]