Medical Record Release Authorization for Research Participation

Date: ______________________

To Whom It May Concern:

I, **[Full Name]**, born on **[Date of Birth]**, hereby authorize the release of my medical records and health information as specified below for the purpose of research participation.

Research Study Title: [Title of the Study]

Research Institution: [Institution Name]

Researcher's Name: [Researcher's Full Name]

Please release the following medical records:

- [Specify type of records, e.g., complete medical history]
- [Specify additional records if necessary]

This authorization is valid until **[Expiration Date]** or until I revoke it in writing.

I understand that I have the right to withdraw my authorization at any time without affecting my treatment or eligibility for the research.

By signing below, I confirm that I have read and understood this authorization.

Signature: ____________________________

Printed Name: ________________________

Date: _____________________________

If applicable, please provide guardian's information:

Guardian's Name: _______________________

Relationship to Participant: ______________

Signature: ____________________________

Thank you for your cooperation.