Medical Record Release Authorization

Date: _____________

To Whom It May Concern,

I, **[Patient's Full Name]**, born on **[Date of Birth]**, hereby authorize **[Healthcare Provider's Name]** to release my medical records to **[School's Name]** for the purpose of **[Reason for Request, e.g., enrollment, health assessment]**.

Please include the following information in the release:

- Medical history
- Immunization records
- Any other pertinent health information

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

Signature: _________________________

Printed Name: ______________________

Date: ______________________________

If you have any questions, please contact me at **[Your Phone Number]** or **[Your Email]**.

Thank you for your cooperation.

Sincerely,

[Your Full Name]