Medical Record Release Authorization

Patient Information:

Name: [Patient's Name]

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

Address: [Patient's Address]

Recipient Information:

Name: [Recipient's Name]

Organization: [Recipient's Organization]

Address: [Recipient's Address]

Authorization:

I, [Patient's Name], hereby authorize [Healthcare Provider's Name] to release my medical records to [Recipient's Name] for the purpose of [specific purpose, e.g., "continuity of care"].

Details of Records to be Released:

[Specify type of records, e.g., "all medical records," "only the records related to treatment for X condition," etc.]

Signature: _____

Date: [Date]

This authorization is valid until [expiration date, e.g., "one year from date of signature"].

Patient's Right to Revoke: I understand that I have the right to revoke this authorization at any time by providing written notice to [Healthcare Provider].