Disability Benefits Consent Letter

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], born on [Your Date of Birth], residing at [Your Address], hereby give my consent for the release of any medical information pertinent to my disability claim.

I understand that this information may be used to assess my eligibility for disability benefits provided by [Specify the Institution or Agency]. I authorize [Name of Medical Provider/Institution] to disclose my medical records, including diagnosis, treatment details, and any other relevant information needed for the evaluation of my application.

This consent is given with the understanding that the information will be kept confidential and will only be used for the purposes outlined above.

Thank you for your attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Contact Information]