[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Recipient Name]
[Recipient Title]
[Institution/Organization Name]
[Institution/Organization Address]
[City, State, Zip Code]
Subject: Authorization to Release Health Records
Dear [Recipient Name],
I, [Your Full Name], born on [Your Date of Birth], hereby authorize [Healthcare Provider/Institution Name] to release my health records to [Recipient Name/Organization] at the following address:
[Recipient's Address]
[City, State, Zip Code]
I understand that the information to be released may include sensitive health information, and I consent to the release of this information for the following purpose(s):
[State the purpose, e.g., medical consultation, insurance verification, etc.]
This authorization is valid until [Expiration Date] unless revoked earlier in writing.
Thank you for your attention to this matter.
Sincerely,
[Your Signature]
[Your Printed Name]
[Your Date of Birth]
[Your Social Security Number (optional)]