[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Recipient's Name]
[Recipient's Title/Position]
[Medical Facility Name]
[Facility Address]
[City, State, Zip Code]

Subject: Authorization Letter for Medical Purposes

To Whom It May Concern,

I, [Your Name], hereby authorize [Authorized Person's Name] to act on my behalf in all medical matters concerning my health and treatment. This authorization includes, but is not limited to, accessing medical records, discussing medical information, and making decisions regarding my medical care.

Details of my medical information include:

- Patient Name: [Your Name]
- Date of Birth: [Your Date of Birth]
- Medical Record Number: [Your Medical Record Number, if applicable]

This authorization is valid from [Start Date] to [End Date].

Thank you for your attention to this matter. Please do not hesitate to contact me at [Your Phone Number] or [Your Email Address] if you have any questions.

Sincerely,

[Your Signature]

[Your Printed Name]