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

Dear [Recipient's Name],

Subject: Medical Authorization

I, [Your Full Name], born on [Your Date of Birth] and residing at [Your Address], hereby authorize [Recipient's Name or Medical Facility] to obtain, use, or disclose my medical records and health information for the purpose of [specific purpose, e.g., treatment, consultation, or insurance claims].

This authorization includes, but is not limited to, the following medical information:

- [Specify the information, e.g., diagnostic tests, medical history, treatment records]

I understand that I have the right to revoke this authorization at any time by providing written notice to [Recipient's Name or Medical Facility].

This authorization will remain in effect until [end date or specify "until revoked"].

Thank you for your attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]
[Your Printed Name]