[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Recipient's Name]
[Recipient's Title]
[Company/Organization Name]
[Company Address]
[City, State, Zip Code]
Subject: Authorization to Release Information
Dear [Recipient's Name],
I, [Your Full Name], born on [Your Date of Birth], hereby authorize [Company/Organization Name] to release my personal information to [Name of the person or organization you are authorizing], for the purpose of [describe the purpose, e.g., medical treatment, employment verification, etc.].
The information to be disclosed includes:
- [Specify the information to be released, e.g., medical records, employment history, etc.]
This authorization is valid until [end date or state that it remains in effect until revoked], and I understand that I may revoke this authorization at any time by providing written notice to [Company/Organization Name].
Sincerely,
[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Relationship to the Individual (if applicable)]