[Your Name]
[Your Title/Position]
[Your Organization]
[Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Recipient Name]
[Recipient's Address]
[City, State, Zip Code]
Dear [Recipient Name],
Subject: Authorization for Release of Patient Information
I, [Patient's Full Name], born on [Patient's Date of Birth], hereby authorize the release of my medical information as described below.

Patient Information
- Name: [Patient's Full Name]
- Date of Birth: [Patient's Date of Birth]
- Medical Record Number: [Patient's MRN] (if applicable)
Information to be Released
I authorize the release of my medical records including:
- [Specify types of records, e.g., medical history, treatment records, lab results]
Purpose of Release
The information is being released for the following purpose:
- [Specify purpose, e.g., legal reasons, continuation of care, etc.]
Recipient of Information
Please send the requested information to:
- [Recipient Name/Organization]
- [Recipient's Address]
- [Recipient's Email/Phone Number if applicable]
Expiration
This authorization will expire on [Expiration Date].
I understand that I may revoke this authorization at any time by providing written notice to [Your Organization's Name], except to the extent that action has already been taken based on this authorization.
Signature

_____
[Patient's Signature]
[Date]
Thank you for your attention to this matter.
Sincerely,
[Your Name]
[Your Title/Position]
[Your Organization]