[Your Organization's Letterhead]
[Date]
[Recipient's Name]
[Recipient's Title]
[Recipient's Organization]
[Recipient's Address]
[City, State, Zip Code]
Subject: Release of Information
Dear [Recipient's Name],
I, [Releasor's Full Name], born on [Date of Birth], hereby authorize the release of my information as specified below:
Information to be Released:
- [Specify the type of information, e.g., medical records, educational records, etc.]
- [Include any specific details, such as dates or types of records]
Purpose of Release:
- [State the reason for the information release, e.g., for health care purposes, legal reasons, etc.]
Recipient of Information:
- [Name of the individual or organization receiving the information]
- [Address of recipient]
Expiration of Release:
This authorization will expire on [specific date or event].
I understand that I have the right to revoke this authorization at any time by providing a written notice to [Organization's Name]. I assume full responsibility for this authorization and acknowledge that I may refuse to sign this release without affecting my rights.
Thank you for your prompt attention to this matter.
Sincerely,
[Releasor's Signature]
[Releasor's Printed Name]
[Contact Information]