[Your Name]
[Your Address]
[City, State, ZIP Code]
[Email Address]
[Phone Number]
[Date]
[Recipient's Name]
[Recipient's Title]
[Recipient's Organization]
[Organization's Address]
[City, State, ZIP Code]

Dear [Recipient's Name],

Subject: Medical Release Authorization

I, [Your Full Name], born on [Date of Birth], hereby authorize [Name of Healthcare Provider or Organization] to release my medical records and information to [Recipient's Name or Organization] for the purpose of [Specify Purpose, e.g., continued care, legal proceedings, etc.].

I understand that this information may include details about my medical history, diagnoses, treatment plans, and any other medical-related information deemed necessary.

This authorization is valid until [Expiration Date or Event] unless I revoke it in writing before that date.

Thank you for your attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Date of Birth]
[Patient's Social Security Number or ID (if necessary)]