[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Recipient's Name]
[Medical Facility's Name]
[Medical Facility's Address]
[City, State, Zip Code]
Subject: Authorization to Access Medical Records
Dear [Recipient's Name],
I, [Your Full Name], born on [Your Date of Birth], hereby authorize [Authorized Person's Name] to access my medical records from [Medical Facility's Name] for the purpose of [state purpose, e.g., personal review, transfer of care, etc.].
This authorization includes access to all medical information, including but not limited to, diagnoses, treatment records, and any other pertinent information related to my health.
Please provide [Authorized Person's Name] with all necessary assistance in obtaining these records. This authorization is valid until [expiration date or condition, if applicable].
Thank you for your attention to this matter.
Sincerely,
[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Date of Birth]
[Your Medical Record Number (if applicable)]