Authorization Letter Form Sample for Medical Records

This **authorization letter form sample** for medical records provides a clear template to grant permission for the release of personal health information. It ensures compliance with privacy laws while facilitating the sharing of medical data between healthcare providers. Use this form to securely authorize access to your medical history.

Authorization Letter Form

Date:

Patient Name:

Date of Birth:

Address:

To (Healthcare Provider/Facility):

Provider Address:

Description of Records to be Released:

Purpose of Disclosure:

I hereby authorize the above named healthcare provider/facility to release my medical records as described to:

Recipient Name/Organization:

Recipient Contact Information:

This authorization is valid until (date or event):

I understand that I may revoke this authorization at any time by submitting a written request, except to the extent that action has already been taken in reliance on this authorization.

Signature of Patient/Legal Representative:

If Legal Representative, state relationship to patient:

Submit