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| **Authority Letter** | [Email] |
| Medical Records Release | [Address] |
|  | [Phone] |

TO [Receiver Name] [Receiver Title]

**Subject:** Notarized Letter of Authorization for Medical Records Release

To Whom It May Concern,

I, [Your Full Legal Name], hereby authorize [Medical Facility's Name] to release my medical records to [Recipient's Name], who is [Your Relationship to Recipient, e.g., my attorney, my new doctor].

This authorization includes the release of all medical records, including but not limited to doctor's notes, test results, treatment plans, and imaging reports. I understand that this release is for the purpose of [Specify Purpose, e.g., legal representation, continuity of care].

By notarizing this letter, I affirm that I have willingly granted this authorization and understand the information that will be disclosed to [Recipient's Name].

Sincerely,

[Your Full Legal Name]

[Notarization Statement]