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

**Subject:** Authorization Letter to Collect Medical Records

To Whom It May Concern,

I am writing to formally authorize [Authorized Person's Full Name] to collect my medical records on my behalf from [Name of Medical Facility]. I am unable to personally visit the facility due to [provide a brief reason, such as illness, travel, etc.]. I trust that [Authorized Person's Full Name] will handle this matter with the utmost care and discretion.

**Below are the details of the authorized person:**

Full Name: [Authorized Person's Full Name]

Date of Birth: [Authorized Person's Date of Birth]

Relationship to Me: [Authorized Person's Relationship to You]

Contact Number: [Authorized Person's Phone Number]

Email Address: [Authorized Person's Email Address]

I understand that by granting this authorization, I am allowing [Authorized Person's Full Name] to access and collect any and all medical records pertaining to my treatment at [Name of Medical Facility]. This includes, but is not limited to, medical history, test results, diagnoses, treatment plans, and any other relevant information.

I hereby release [Name of Medical Facility], its staff, and any associated personnel from any liability or responsibility for releasing my medical records to [Authorized Person's Full Name]. I acknowledge that any information obtained by [Authorized Person's Full Name][Authorized Person's Full Name] is for my personal use and benefit.

This authorization is valid from [Starting Date] to [Ending Date], unless revoked or extended in writing by me. I may be reached at the contact details provided above for any further verification or inquiries.

Thank you for your understanding and cooperation in this matter. I appreciate your assistance in ensuring the smooth retrieval of my medical records.

Sincerely,

[Your Full Legal Name]

[Your Signature – if submitting a physical copy]