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

TO [Receiver Name] [Receiver Title]

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

To Whom It May Concern,

I am writing to formally authorize Mr. Michael Johnson to collect my medical records on my behalf from City Central Hospital. I am unable to personally visit the facility due to my recent surgery. I trust that Mr. Michael Johnson will handle this matter with the utmost care and discretion.

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

Full Name: Mr. Michael Johnson

Date of Birth: April 5, 19XX

Relationship to Me: Brother

Contact Number: (555) 987-6543

Email Address: michael.johnson@email.com

I understand that by granting this authorization, I am allowing Mr. Michael Johnson to access and collect any and all medical records pertaining to my treatment at City Central Hospital. This includes, but is not limited to, medical history, test results, diagnoses, treatment plans, and any other relevant information.

I hereby release City Central Hospital, its staff, and any associated personnel from any liability or responsibility for releasing my medical records to Mr. Michael Johnson. I acknowledge that any information obtained by Mr. Michael Johnson is for my personal use and benefit.

This authorization is valid from August 15, 20XX, to September 15, 20XX, 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,

Jane Doe