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| **Authority Letter** | [Email] |
| Release Information | [Address] |
|  | [Phone] |

TO [Receiver Name] [Receiver Title]

Dear [Medical Records Custodian's Name],

I, [Your Name], hereby authorize [Medical Facility Name] to disclose my medical records to [Third Party's Name], for the purpose of [state the purpose, e.g., legal proceedings, medical consultation, etc.].

The specific information that may be released includes but is not limited to diagnosis, treatment details, laboratory results, and any other relevant medical information.This authorization is valid for a period of [duration] from the date of this letter, unless otherwise specified or revoked in writing.

I kindly request that you ensure the confidentiality of my medical information during the release and transmission process. If you need any further information or have any questions, please contact me at [Your Email Address] or [Your Phone Number].

Thank you for your assistance in this matter.

Sincerely,

[Your Full Name]

[Your Signature]