Authorization Letter

(Medical Records Authorization Letter**)**

[Your Name]
[Your Address]
[City, State, ZIP Code]

[Date]

[Healthcare Provider/Hospital Name]
[Provider/Hospital Address]

[City, State, ZIP Code]

Dear [Healthcare Provider/Hospital Name],

I, [Your Name], hereby authorize [Authorized Person's Name] to request and obtain copies of my medical records from [Healthcare Provider/Hospital Name]. [Authorized Person's Name] is permitted to collect these records on my behalf for personal or legal purposes.

This authorization is valid until [End Date].

Thank you for your cooperation.

Sincerely,
[Your Signature]
[Your Name]