

AUTHORIZATION LETTER FOR THE RELEASE OF EMPLOYEE MEDICAL RECORDS

I, _____ hereby authorize _____
(Full name of employee) (Name of Organization)

to release to **Your Company Name**, the following medical record(s):

(Give specific description of the information to be released)

I give my permission for the medical information to be used for the following purpose(s):

_____ I do not give permission for any other use or reason.

_____ I understand that this authorization expires twelve (12) months from today's date unless I
specify a particular date less than twelve (12) months which is: _____.

Signature of employee or his/her legal representative Date of Signature

Reviewed on _____ with _____
(Date) (Signature of Organization's Representative)

Copies given? ☐ Yes ☐ No