Medical Information Release Authorization for Disability Insurance

Personal Information

Full Name

Date of Birth

Address

Phone Number

Disability Insurance Policy Number (if known)

Recipient of Medical Information

Name/Organization

Address

Authorization Scope

Type of Information to be Released

e.g., All medical records, specific diagnosis/treatment, or time period

Purpose of Disclosure

e.g., Disability Insurance Claim Processing

Authorization Statement

I hereby authorize the release of my medical information as described above, including diagnosis, treatment records, and other related data, to the recipient listed for the specified purpose. I understand that this authorization is voluntary and that I may revoke it at any time in writing, except to the extent actions have already been taken based on this authorization. This authorization will expire one year from the date signed unless otherwise specified below.

Expiration Date (if other than one year from signature):

Signature of Applicant

Date

Printed Name

Relationship to Applicant (if not self)

A photocopy or electronic copy of this authorization is as valid as the original.