

Medical Information Disclosure Consent

I hereby authorize the disclosure of my medical information as described below:

Patient Name:

Date of Birth:

Information to be disclosed to (Name/Organization):

Purpose of Disclosure:

Type of Information Authorized for Disclosure:

- ☐ Medical Records
- ☐ Diagnosis
- ☐ Treatment Summary
- ☐ Other

This consent expires on (date):

Signature:

Date Signed:

Submit