Consent to Share Health History

I, _____, hereby give my consent to _____ to share my health history information as described below:

Date of Birth: _____

Recipient of Health Information: _____

Purpose of Disclosure: _____

Type of Information to be Shared:

- ☐ Medical History
- ☐ Mental Health
- ☐ Prescription Records
- ☐ Other (please specify): _____

Authorization Expiration Date: _____

I understand that this consent is voluntary and I may revoke it at any time by notifying the provider in writing.

Signature: _____

Date: _____