

Consent for Disclosure of Health Records

I, [REDACTED], born on [REDACTED], hereby give my consent for the disclosure of my health records by [REDACTED] to [REDACTED] for the purpose of [REDACTED]

Type of records to be disclosed:

- Medical
- Surgical
- Mental Health
- Other: [REDACTED]

This consent is valid until [REDACTED] unless revoked in writing.

Signature: [REDACTED] Date: [REDACTED]