

## Consent to Release Health Information

I, [REDACTED], hereby authorize the release of my health information as described below.

Date of Birth: [REDACTED]

Address: [REDACTED]

Phone Number: [REDACTED]

Release my records to: [REDACTED]

Purpose of Release: [REDACTED]

Information to be Released:

Medical History

Test Results

Immunizations

Other: [REDACTED]

This consent expires on: [REDACTED]

Signature: [REDACTED]

Date: [REDACTED]