

## Patient Consent for Health Data Release

I, , hereby authorize  to release my health data as described below.

Date of Birth:

Type of Information to be Released:

- ☐ Medical History  
☐ Laboratory Results  
☐ Imaging Reports  
☐ Other

Purpose for Data Release:

Release To (Name/Organization):

Expiration Date of Consent:

I understand that I may revoke this consent at any time by providing written notice.

☐ I acknowledge and agree to the above terms.

Patient Signature:

Date:

Submit