Medical Information Disclosure Consent

I, _____, hereby authorize the disclosure of my medical information as described below.

Date of Birth: _____

Name of Healthcare Provider: _____

Information to be disclosed:

- ☐ Diagnosis
- ☐ Treatment
- ☐ Billing Information
- ☐ Other _____

Person/Organization to receive information: _____

Purpose of disclosure: _____

This consent is valid until: _____

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

Patientâ€™s Signature: _____

Date: _____

Submit