Consent to Release Confidential Health Information

I hereby authorize _____ to release my confidential health information as specified below to _____.

Patient Information

Full Name: _____

Date of Birth: _____

Information to be Released

_____

Purpose of Disclosure

_____

☐ This includes sensitive information (e.g., mental health, HIV, etc.)

This consent will expire on _____ unless revoked in writing earlier.

Signature

Signature: _____

Date: _____

Submit