Permission to Disclose Patient Information

I, _____ (Patient Name), hereby authorize the disclosure of my medical information as specified below.

Date of Birth: _____

Address: _____

Recipient of Information (Name/Institution): _____

Details of Information to Disclose:

_____

Purpose of Disclosure: _____

Expiration Date of Permission: _____

Signature of Patient/Representative: _____

Date: _____

I understand that this permission is voluntary and that I may revoke it at any time in writing.