Consent Form for Health Information Release

I, _____, hereby give my consent for the release of my health information as described below.

Patient Information

Date of Birth: _____

Address:
_____

Recipient of Information

Name/Organization: _____

Address:
_____

Purpose of Release

_____

Information to be Released

- ☐ Medical History
- ☐ Laboratory Results
- ☐ Other: _____

Authorization Dates

From: _____ To: _____

I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken.

Signature of Patient/Representative:
_____

Date: _____

Submit