

Consent to Release Insurance Information

I hereby authorize **[Name of Healthcare Provider]** to release my insurance information to:

Recipient Name/Organization:

Insurance Policy Number:

Purpose of Disclosure:

Patient Name:

Date of Birth:

Signature:

Date:

I understand that I may revoke this consent at any time by providing written notice. This consent will remain in effect until revoked or upon expiration of one year from the date signed.