

Patient Consent to Disclose Health Information

I, [REDACTED], hereby authorize [REDACTED] to disclose my health information as described below.

Date of Birth: [REDACTED]

Recipient of Information: [REDACTED]

Information to be disclosed: [REDACTED]

Purpose of Disclosure: [REDACTED]

I understand that I may revoke this consent at any time in writing. This consent will expire on [REDACTED].

Signature of Patient: [REDACTED] Date: [REDACTED]