Insurance Information Sharing Consent Document

By signing this document, you authorize **[Insurance Provider Name]** to share your insurance information with the parties listed below for the purposes of claims processing, benefits coordination, and coverage verification. Your consent is voluntary, and you may withdraw it at any time by notifying us in writing.

Your Information

Full Name:

Policy Number:

Date of Birth:

Parties Authorized to Receive Information

- Healthcare Providers
- Claims Processors
- Legal Representatives (if applicable)

Consent Confirmation

☐ I hereby give my consent for **[Insurance Provider Name]** to share my insurance information as described above.

Signature:

Date: