Consent to Share Personal Health Information

I, _____, hereby give consent to _____ to share my personal health information with:

Recipient Name/Organization: _____

Purpose of disclosure: _____

Type of Information to be Shared:

- ☐ Medical Records
- ☐ Test Results
- ☐ Treatment History
- ☐ Billing Information
- ☐ Other _____

This consent is valid from _____ to _____

I understand that I may withdraw my consent at any time by notifying _____ in writing.

Signature: _____ Date: _____