Consent for Accessing Personal Health Information

Date: _____

To Whom It May Concern,

I, **[Your Full Name]**, hereby give my consent for **[Healthcare Provider/Institution Name]** to access my personal health information online. I understand that this information will be used for the purpose of **[State Purpose, e.g., continued care, research, etc.]**.

I acknowledge that I have the right to revoke this consent at any time by providing a written notice to **[Healthcare Provider/Institution Name]**.

Details of my personal information include:

- Full Name: [Your Full Name]
- Date of Birth: [Your Date of Birth]
- Patient ID (if applicable): [Your Patient ID]

This consent will remain in effect until **[Specify Duration]** unless revoked earlier.

By signing below, I affirm that I understand the contents of this letter and consent to the access of my personal health information as described.

Signature: _____

Printed Name: _____

Date: _____