Consent to Access Medical Records

Patient Name: [Patient's Full Name]

Date of Birth: [Patient's Date of Birth]

Address: [Patient's Address]

Phone Number: [Patient's Phone Number]

I, the undersigned, hereby give my consent for [Name of Healthcare Provider/Facility] to access and review my medical records for the purpose of [specific purpose, e.g., continuing care, legal reasons, etc.].

I understand that my medical records contain sensitive information, and I authorize the release of the details necessary for this purpose.

Authorized Recipient: [Name of Recipient/Institution]

This consent is valid until [expiration date or event], unless revoked by me in writing.

Patient's Signature: ______________________

Date: ______________________

If you have any questions regarding this consent form, please contact me at the provided phone number.