Health History Disclosure

Date: _____

To Whom It May Concern,

I, **[Your Full Name]**, born on **[Date of Birth]**, hereby authorize **[New Medical Practice Name]** to obtain my health history from my previous medical providers.

My previous providers include:

- Provider Name: **[Provider 1 Name]**, Phone: **[Provider 1 Phone]**
- Provider Name: **[Provider 2 Name]**, Phone: **[Provider 2 Phone]**
- Provider Name: **[Provider 3 Name]**, Phone: **[Provider 3 Phone]**

I understand that my health history may include sensitive information and I consent to the sharing of this information for the purpose of my medical care.

Thank you for your attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Phone Number]

[Your Email Address]