# Consent for Access to Health Records

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], born on [Date of Birth], hereby give my consent for [Name of Individual/Organization] to access my health records maintained by [Name of Healthcare Provider/Facility].

I understand that the information contained in my health records may include sensitive information. I authorize the release of all relevant medical information including, but not limited to:

- Medical history
- Diagnostic test results
- Treatment notes

This consent is valid until [Specify Duration or Termination Condition], and I have the right to revoke it at any time by providing written notice.

Thank you for your attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Address]

[Your Phone Number]