Health Information Release Consent

Date: _____

To Whom It May Concern,

I, **[Patient's Full Name]**, born on **[Date of Birth]**, hereby authorize **[Healthcare Provider's Name]** to release my health information to:

[Recipient's Name]
[Recipient's Address]
[Recipient's Phone Number]

The information to be released includes:

- Medical Records
- Lab Results
- Radiology Reports
- Other: _____

This consent is valid for **[Specify Duration]** from the date of signing.

I understand that I may revoke this consent at any time by providing a written notice to **[Healthcare Provider's Name]**. I understand that my health information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Signature: _____

Printed Name: **[Patient's Full Name]**

Contact Information: **[Patient's Phone Number]**

If signed by someone other than the patient, please indicate your relationship to the patient: **[Relationship]**

Thank you.