Patient Consent for Health Information Disclosure

Date: _____

To Whom It May Concern,

I, **[Patient's Full Name]**, born on **[Patient's Date of Birth]**, hereby give my consent to **[Healthcare Provider's Name]** to disclose my health information as outlined below.

Information to Be Disclosed:

- Medical history
- Treatment information
- Test results
- Other: _____

Purpose of Disclosure:

- Continuity of care
- Insurance claims processing
- Legal reasons
- Other: _____

Recipient of the Information:

[Name of the person or organization receiving the information]

This consent is valid until **[Expiration Date]** unless revoked by me in writing prior to that date.

I understand that I have the right to revoke this consent at any time by notifying **[Healthcare Provider's Name]** in writing.

Patient Signature: _____

Patient Name (Printed): _____

Date: _____

Witness Signature: _____

Witness Name (Printed): _____

Date: _____