Permission to Share Medical History

Date: _____

To Whom It May Concern,

I, [Your Full Name], born on [Your Date of Birth], residing at [Your Address], hereby give my consent for [Healthcare Provider/Organization Name] to share my medical history with [Recipient's Name/Organization] for the purpose of [specific reason for sharing].

I understand that my medical history will include information regarding [list specific information, e.g., diagnoses, treatments, medications].

This permission is granted for the duration of [Time Period] or until I provide written notice to revoke it.

Should you have any questions regarding this authorization, please feel free to contact me at [Your Phone Number] or [Your Email Address].

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]