

# Patient Consent to Release Information Form Sample

The **patient consent to release information form sample** is a crucial document that authorizes healthcare providers to share medical records with specified individuals or organizations. It ensures compliance with privacy laws while facilitating seamless communication between patients and third parties. Using this form protects patient rights and supports efficient information exchange in medical settings.

## Sample Form

Patient Information

Full Name:

Date of Birth:

Address:

Recipient Information

Recipient Name/Organization:

Contact Details:

Information to be Released

☐ Medical History

☐ Lab Results

☐ Imaging Reports

☐ Other (please specify):

Purpose of Disclosure

Consent

I hereby authorize the release of my medical information as specified above to the recipient(s) listed. I understand that this consent is voluntary and may be revoked by me at any time in writing.

Patient Signature:

Date:

Submit