Medical Consent to Release Information Form

The **Medical consent to release information form** example helps patients authorize healthcare providers to share their medical records with designated parties. This legally binding document ensures privacy and compliance with healthcare regulations. Proper completion of the form facilitates efficient communication and continuity of care.

Patient Information

Full Name:

Enter full name

Date of Birth:

Phone Number:

Enter phone number

Information to Be Released

Specify Information:

e.g., complete medical record, lab results, X-rays, etc.

Recipient of Information

Name or Organization:

Enter recipient's name or organization

Contact Information:

Enter address, email, or fax

Purpose of Disclosure

Purpose:

e.g., continued treatment, insurance, personal use

Authorization and Signature

☐ **I authorize the release of the specified information as indicated above.**

Signature of Patient/Representative:

Sign or type full name

Date:

Note: This form is an example. Always consult with your healthcare provider or legal adviser before using.