Patient Consent and Authorization Form

Patient Name

Date of Birth

Address

Consent and Authorization

I hereby authorize and consent to the collection, use, and disclosure of my health information as necessary for the purposes of medical evaluation, treatment, healthcare operations, and insurance processing.

I understand that my information will be handled in accordance with applicable privacy laws and that I have the right to revoke this consent at any time by notifying the healthcare provider in writing.

☐ I have read and understood the above information.

☐ I authorize the release of my medical information as described.

Patient Signature

Date

If patient is a minor or unable to sign, authorized representative:

Relationship to Patient