Consent to Release Health Records to Insurance Provider

Patient Information

Full Name:

Date of Birth:

Address:

Details of Records to be Released

I authorize the release of my health records to:

Insurance Provider Name:

Insurance Policy Number:

Authorization

I, the undersigned, hereby authorize the release of my health records, including medical history, test results, consultations, and treatment information, to the insurance provider listed above for the purpose of claims processing and/or coverage determination.

This consent is valid for one year from the date signed below or until I revoke my consent in writing.

Patient Signature

Date