Medical Information Sharing Consent Agreement

I,

Full Name

, born on

, hereby give my consent to share my medical information as described below.

Purpose of Information Sharing

My medical information may be shared for the following purpose(s):

e.g. Coordination of care, referral, insurance purposes

Information to Be Shared

e.g. Diagnosis, treatment, medical history

Entities Authorized to Receive Information

e.g. Healthcare provider, insurance company

Duration of Consent

This consent is valid from

to

unless revoked earlier in writing.

Patient Acknowledgement

- I understand that I have the right to revoke this consent at any time by notifying my healthcare provider in writing.
- I understand that disclosure of my information is voluntary and may be necessary for my care or other specified purposes.
- I have been informed of my rights regarding my medical information and have had the opportunity to ask questions.

Patient Signature

Date

Witness Signature

Date