Medical Records Information Disclosure Consent

Patient Information

Full Name

Enter full name

Date of Birth

MM/DD/YYYY

Patient ID / MRN

Enter ID or MRN

Recipient Information

Recipient Name / Organization

Contact Details

Information to be Disclosed

Please specify the records or information to disclose

Purpose of Disclosure

Please specify the purpose

I hereby authorize the release of my medical records/information as specified above. This authorization is valid until the expiry date or until revoked in writing.

Consent Expiry Date

MM/DD/YYYY

Patient Signature

Date

MM/DD/YYYY

Witness (if required)

Date

MM/DD/YYYY