Patient Consent for Provider Communication Disclosure

I hereby authorize communication and disclosure of my health information between my healthcare providers for the purposes of coordination and continuity of care.

Patient Name

Date of Birth

Names of Provider(s) Authorized

Purpose of Disclosure

Coordination of care

Information to be disclosed

I understand that:

- This consent is voluntary.
- I may revoke this authorization at any time in writing.
- Refusal to sign will not affect my ability to obtain treatment.
- Information disclosed may be re-disclosed by the recipient and may no longer be protected under law.

Signature of Patient or Legal Representative

Date