Standard Patient Information Disclosure Consent Form

This form authorizes the disclosure of protected health information in accordance with federal and state privacy regulations. Please complete all sections below.

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1. Patient Information

Patient Full Name:	
Date of Birth (MM/DD/YYYY):	
Phone Number:	
Street Address:	

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2. Authorization to Disclose

I hereby authorize the following entity to release my protected health information:

Disclosing Facility/Provider Name:

I authorize this information to be disclosed to the following recipient:

Recipient Name/Organization:	
Recipient Address:	
Recipient Phone Number:	

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3. Scope and Purpose of Disclosure

Describe the specific information to be disclosed (e.g., medical records from specific dates, lab results, imaging reports):

Description of Information:

Describe the purpose of this disclosure (e.g., continued medical care, personal use, legal proceedings, insurance claim):

Purpose of Disclosure:

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4. Expiration and Revocation

This authorization will expire on the following date or event. If no date is specified, this authorization will expire one year from the date of signature.

Expiration Date or Event:

I understand that I have the right to revoke this authorization at any time by providing written notice to the disclosing provider, except to the extent that action has already been taken in reliance on this authorization.

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5. Patient Signature and Consent

By signing below, I acknowledge that I have read and understand this consent form. I authorize the use and disclosure of my protected health information as described above.

Signature of Patient or Legal Representative:	
Date Signed (MM/DD/YYYY):	
Relationship to Patient (if signed by Representative):	