
Consent to Disclose Information

Care Provider: _____
Address: _____
Phone: _____ Fax: _____
Email: _____

Patient: _____
Date of birth: _____
Medicare number: _____
Social security/insurance number: _____
Insurance provider: _____

I, _____ authorize _____
to disclose information to the following person(s):

1. _____
2. _____
3. _____
4. _____
5. _____

This disclosure includes, but is not limited to: general health, diagnoses, treatment, medication, recommendations, and any other information that is important to my health status.

Please note the following specific requests:

I understand that I may revoke this consent in writing at any time.

Patient signature

Date

Disclaimer: This form may not be recognized as valid in some states or provinces. Check with your local legal offices for details.