



Consent to Disclose Information

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

From:
 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