



**CONSENT TO DISCLOSE
PERSONAL HEALTH INFORMATION**

Patient Name: _____

Date of Birth: _____

Address: _____

Telephone#: _____

Unit#: _____

I, _____ hereby authorize _____
to disclose the following personal health information

(Description of personal health information to be disclosed and dates of contact / hospitalization)

Emergency visit on: _____

Outpatient visit on: _____

Inpatient visit from: _____

to _____
(Name and address of person / agency requesting information)

From the records of: _____
Name of Patient Birth Date

Mailing Address of Patient: _____

I understand that this information is to be used only by the recipient for the purpose of

Dated this _____ day of _____ 20____ .

I hereby waive any and all claims against _____ in connection with the
disclosure of this personal health information.

Signature of patient
(or legally authorized person)

Relationship to patient

Signature of Witness