

## GENERAL EXPRESS CONSENT FORM

DATE: \_\_\_\_\_

I, \_\_\_\_\_ (patient name)

consent to \_\_\_\_\_ (physician name)

disclosing relevant portions or a summary of my medical record to

\_\_\_\_\_ (to whom disclosed)

for the purpose of \_\_\_\_\_ (purpose).

\_\_\_\_\_

(Patient Signature)