

Consent for Use and Disclosure of Health Information



Section A: Patient/Applicant/Participant Giving Consent

Name: _____

Address: _____

Telephone: (____) _____ Fax: (____) _____

Section B: To the Patient/Applicant/Participant and Parent/Guardian

Purpose of Consent: By signing this form, you consent to allow your physician, or their authorized representative, to release your protected health information upon request to The Institute of Missionary Evangelism, their authorized representative, or any medical personnel requesting information on behalf of you, the patient/applicant/participant, while traveling to and from the designated TIME site(s), and at any time while at the designated site(s).

I, _____, have had full opportunity to read and consider the contents of this Consent for Use and Disclosure of Health Information. I understand that by signing this form, I am giving my consent to my physician or their authorized representative to release my protected health information to The Institute of Missionary Evangelism, their authorized representative, or any medical personnel requesting information on my behalf.

Signature: Patient/applicant signature: _____ Date: _____

Parent/guardian: _____ Date: _____

Physician's office: Physician Name: _____ Office phone: (____) _____

Address: _____ Fax number: (____) _____

City/State/Zip: _____

After signing, provide the yellow copy to your physician to keep in your chart, in case your medical information is needed.

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Signature: Patient/applicant signature: _____ Date: _____

Parent/guardian: _____ Date: _____

Physician's office: Physician Name: _____ Office phone: (____) _____

Address: _____ Fax number: (____) _____

City/State/Zip: _____

After signing, provide the yellow copy to your physician to keep in your chart, in case your medical information is needed.