Healthcare Provider Data Sharing Agreement Form

Provider Information

Provider Name

Organization Name

Contact Email

Contact Phone

Address

Recipient Information

Recipient/Organization Name

Recipient Email

Data to be Shared

- [ ] Identification Data
- [ ] Medical Records
- [ ] Billing Information
- [ ] Other (please specify)

Purpose of Data Sharing

Data Retention Period

Specify the duration or end date

Authorization

Authorized By (Name & Title)

Date

Additional Terms or Conditions