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**CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION and
RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM**

I, _____, hereby give my consent to
(Name of Patient or Authorized Agent, Please Print)

Dr. Matthew E. Schmidt & Associates to use or disclose, for the purpose of carrying out
treatment, payment, or health care operations, all information contained in the patient record of

(Patient's Name, if different from above, Please Print) _____
(Patient's Date of Birth)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy
Practice provides detailed information about how the practice may use and disclose my
confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are
described in the Notice. I also understand that a copy of any Revised Notice will be provided to
me.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke
this consent at any time by giving written notice of my desire to do so, to the physician. I also
understand that I will not be able to revoke this consent in cases where the physician has already
relied on it to use or disclose my health information. Written revocation of consent must be sent
to the physician's office.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____.

If you need assistance with appointments/surgery scheduling, whom may we contact?

Name: _____ Phone Number: _____

With whom may we share your medical information, please list name(s) and number(s).

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____