MATTHEW E. SCHMIDT, M.D. & ASSOCIATES

MATTHEW E. SCHMIDT, M.D.
7600 West College Drive
Palos Heights, IL 60463

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)
Matthew E. Schmidt, M.D. and 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)

_____ _____