Consent For Release and Use of Confidential Information

I_______________________________________ hereby give my consent to
(Name of patient or Authorized Agent)
DuPage Internal Medicine, LTD., to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all information of the patient record of

____
(Patient's name)

____
(Date of birth)

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 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

_______________________________________.