

**Consent for Release and Use of Confidential Information and
Receipt of Notice of Privacy Practices Letter**



**Thomas Rohde, M.D., LTD
3798 E. Fulton Avenue
Decatur, IL 62521**

I, _____, hereby give my
(Name of Patient or Authorized Agent)

consent to Thomas Rohde, M.D. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.

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 Dr. Rohde has reserved a right to change his privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available.

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 Dr. Rohde or his staff. 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 mailed to Dr. Rohde's office.

You have my permission to release medical/financial information to:

Name	Relationship

Signed: _____ Date: _____

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

_____.