SUBURBAN NEUROLOGISTS, S.C.

Consent for release and use of confidential information and receipt of notice of privacy practice form

I ________________________, hereby give my consent to Suburban Neurologists, S.C. 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)**

I acknowledge receipt of receipt of the physicians Notice of Privacy Practice. The 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 or made available upon request.

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 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 already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I give your office permission to discuss my medical information with family members:

Name: __________________________________ Relationship: ___________________

Name: __________________________________ Relationship: ___________________

Name: __________________________________ Relation ship: ___________________

Signature: ____Date: ______________

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