CONSENT TO RESEARCH PARTICIPATION

Patient_____

Date:_____ **Time:**_____

I give consent to Dr. Mondloch and her designated associates to utilize any pertinent clinical, laboratory or demographic information from my patient record as would be needed for research purposes in a HIPPA compliant fashion.

Signature:_____ Date:_____

Victoria J. Mondloch, MD, S.C.
20800 Swenson Drive Suite 425
Waukesha, WI 53186
Phone:262-524-9116/FX:262-754-4944