Consent and Acknowledgement Form

Patient's name:_____ Date of Birth:_____

1. Release of Information I authorize Sonus to disclose and furnish copies of any information relating to my care at Sonus Alexandria Hearing Care Professionals to:

   • any person or health care provider Sonus believes to be involved in my care;

   • any third party payor or other third party that may provide health-related benefits to me or may be financially responsible for the services I receive;

   • any other person or organization I may specify in writing; and

   • as allowed by applicable state and federal law, any other persons or organizations necessary for my treatment, payment or Sonus health care operations.

In certain cases, such as when I request to have my records sent to another provider, I understand that Sonus may charge me, and I agree to pay, a copying fee for Sonus costs in photocopying and otherwise reproducing records.

2. Effective Date; Revocation I understand that I may revoke this consent at any time by giving written notification to Sonus. This consent expires on the earlier of: (i) the date Sonus received written notice of revocation; or (ii) the date that the consent expires in accordance with governing law. I understand that my revocation will be ineffective to the extent Sonus has relied upon my permission granted in this consent.
3. Additional Rights I understand that a more detailed description of my rights regarding my records is available upon request in the Sonus Notice of Privacy Practices

I authorize Sonus to disclose and furnish copies of my information relating to my care at Sonus Alexandria Hearing Care Professionals to the following person(s) or organization(s):

_____ _____
Person/Organization Date

_____ _____
Person/Organization Date

_____ _____
Person/Organization Date

_____ _____
Signature of Patient (or Legal Representative) **Date**

_____
Printed Name of Patient (or Legal Representative)

_____ _____
Legal Representative's Relationship to Patient **Witness (Sonus)**