Consent and Acknowledgement Form

Patient's	name:	

__ Date of Birth:_

I. Consent for Release of Information

- 1. <u>Release of Information</u>. I authorize Sonus to disclose and furnish copies of any information relating to my care at a Sonus[®] Hearing Care Professionals to:
 - any person or health care provider Sonus believes to be involved in my care;
 - any third party payor or other 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 as 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 or otherwise reproducing the records.

- 2. <u>Effective Date; Revocation</u>. 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 receives a 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 the permission granted in this consent.
- 3. <u>Additional Rights</u>. I understand that a more detailed description of my rights regarding my records can be found in Sonus Notice of Privacy Practices.

II. Acknowledgement of Receipt of Notice

1. <u>Acknowledgement</u>. By signing below, you are acknowledging that you have received a copy of our Notice of Privacy Practices.

* * * *

Signature of Patient (or Legal Representative):

Print Name of Patient (or Legal Representative):

Legal Representatives Relationship to Patient:

Witness (Sonus):



Date: