Consent and Acknowledgement Form

Patient's name:_____ Date of Birth:_____

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I. Consent for Release of Information

1. Release of Information. 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. 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 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. Additional Rights. 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. Acknowledgement. By signing below, you are acknowledging that you have received a copy of our Notice of Privacy Practices.

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_____ _____

Signature of Patient (or Legal Representative): Date:

_____

Print Name of Patient (or Legal Representative):

_____ _____

Legal Representatives Relationship to Patient: Witness (Sonus):