CONSENT FOR RELEASE OF INFORMATION

1. **Release of Information.** I authorize Richard Polhill Professional Hearing Solutions (RPPHS) to disclose and furnish copies of information relating to my care at RPPHS (including any information related to substance abuse, mental health, HIV/AIDS, or other sensitive issues), **to:**

    - Any person or health care provider RPPHS believes to be involved in my care;
    - Any third party pay 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 RPPHS's health care operations. In certain cases, such as when I request to have my records sent to another provider, I understand that RPPHS may charge me, and I agree to pay a copying fee for RPPHS 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 RPPHS. This consent expires on the earlier of: (I) the date RPPHS 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 RPPHS has relied upon the permission granted in the consent.

3. **Additional Rights,** I understand that a more detailed description of my rights regarding my records can be found in the RPPHS's Notice of Privacy Practices.

II PAYMENT AUTHORIZATION

1. **Payment Responsibility.** I agree that I am responsible to pay RPPHS for all services furnished to me at RPPHS, including, any and all amounts which are not paid for by my insurance.

III ACKNOWLEDGMENT OF RECEIPT OF NOTICE

1. **Acknowledgment.** By signing below, you are acknowledging that you have received a copy of our Notice of Privacy Practices.

Signature of patient/customer (or patient/ customer's representative :) _____

Date: _____

Print Name of Patient / Customer: _____Birth Date:_____

If you are signing as the patient's / customer's representative:

Print your name: _____

Describe your authority: _____