

## 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:** \_\_\_\_\_