

**CONSENT AND ACKNOWLEDGMENT FORM**

Patient/Customer’s Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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**I. Consent for Release of Information**

1. **Release of Information.** I authorize Sonus, Inc. (“Sonus”) to disclose and furnish copies of any information relating to my care at Sonus (including any information related to substance abuse, mental health, HIV/AIDS, or other sensitive issues), 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’s 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’s 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’s Notice of Privacy Practices.

**II. Payment Authorization**

1. **Payment Responsibility.** I agree that I am responsible to pay Sonus for all services furnished to me at Sonus, 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: \_\_\_\_\_

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

Print your name: \_\_\_\_\_

Describe your authority: \_\_\_\_\_