ADVANCED HEARING SERVICES, INC (AHS)
An Affiliate of Otolaryngology Associates, PC (OA)
RELEASE OF INFORMATION

I, the undersigned, authorize representatives of AHS/OA to speak with the persons listed below regarding my medical care. I understand that with my signature I am authorizing the release of written or oral communication by AHS/OA to the listed persons and thereby release AHS/OA and their staff from all legal responsibility that may arise from the act hereby authorized.

_____	_____	_____
Authorized Person	Relationship to Patient	Phone Number
_____	_____	_____
Authorized Person	Relationship to Patient	Phone Number

_____ _____

Signature of Patient / Responsible Party Date

RECEIPT OF PRIVACY PRACTICES WITH WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a written summary of AHS's/OA's Privacy Practices. I understand that a complete copy of the group's Notice of Privacy Practices is available, at no charge, upon request.

_____ _____

Signature of Patient/Responsible Party Date