



**AUTHORIZATION FOR RELEASE OF INFORMATION
SOUND HEALTH SERVICES, P.C.**

Patient Name: _____ **Date of Birth:** _____

I understand that Sound Health Services, P.C. (the "practice") has certain right and obligations with regard to my protected health information (information regarding my health and treatment that the Practice may have in it's possession). I also understand that I have certain rights with regard to my protected health information.

I authorize the Practice to provide informational reminders regarding upcoming appointments I may have to me or anyone who may answer the telephone, or to leave such reminders on any telephone answering device or service, at the telephone number(s) I have provided the Practice as telephone numbers at which I may be contacted (other than the telephone number of my place of employment) or at any of the following telephone numbers:

I authorize the Practice to disclose my protected health information to any of the following persons (state the name of the person and the relationship to you):

I understand that I may revoke any authorization granted above by written notice signed by me delivered to the Practice's Privacy Official at the address stated below. My authorization remains valid until revoked, in writing, by me.

I acknowledge receipt of the Practice's Privacy Practices Notice effective September 23, 2013 regarding the Practice's rights and obligations and my rights regarding my Protected Health Information. I acknowledge that I understand that I have the right to request and receive clarifications, explanations or further information with regard to the Practice's Privacy Practices through written request signed by me addressed to the Practice's Privacy Official.

Sound Health Services, P.C.

Attn: R. Brian Vohs

3860 South Lindbergh

St. Louis, MO 63127



Signature of Patient or Patient's Representative

Date

****Basis of representative's authority to act for patient:** _____