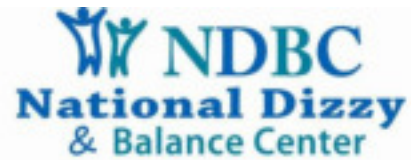


National Dizzy & Balance Center  
Burnsville (952) 808-9000  
Coon Rapids (763) 786-6900  
Edina (952) 345-3000  
St. Paul (651) 221-0303



**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

**PATIENT INFORMATION:**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**AUTHORIZED FACILITY:**

National Dizzy & Balance Center

**AUTHORIZED THIRD PARTY:** Written and verbal medical information may be released to and received from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL INFORMATION:** Indicate the information that you are authorizing to be released.

Specific Dates of Treatment: \_\_\_\_\_

All Medical Information (History and physical exams, physician consultation reports, diagnostic testing reports, physical therapy evaluations and daily notes, and discharge summaries).

**OR** to only release specific portions of your medical information, indicate the categories to be released:

History and Physical Exams

Physician Consultation Reports

Diagnostic Balance Lab Testing Reports  
(VNG, Hearing Test, CDP, MRI/MRA)

Evaluation and Treatment Information  
(diagnosis, medications, plan of care)

Scheduling/Appointment Information

Billing and Payment Information

Other: \_\_\_\_\_

**REASON(S) FOR RELEASING INFORMATION:** Indicate the reason you are authorizing this release.

Patient Request  Continuation of Care  Payment  Legal  Other: \_\_\_\_\_

I understand that by signing this form, I am authorizing that the medical information specified above be sent to the third party named. I may cancel this consent at any time by writing to the facility listed. I understand that when the medical information is sent to the third party named above, the information may be re-disclosed by the third party that receives it, and may no longer be protected by federal or state privacy laws.

**PATIENT'S SIGNATURE:** This authorization will be in effect for 12 months from the date signed, unless the facility receives a cancellation by me in writing.

Signature of Patient/Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

Printed Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

If Authorized Representative, Relationship to Patient: \_\_\_\_\_