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: _____