Vestibular Therapy Specialists

Seattle Clinic
10564 5th Ave NE, #405
Seattle, WA 98125

P: 206.672.0145
F: 855.564.1831

Bend Clinic
477 NE Greenwood Ave
Bend, OR 97702

P: 451.639.4598
F: 855.564.1831

MEDICAL RECORDS RELEASE FORM
TO VESTIBULAR THERAPY SPECIALISTS

Patient Name: _____ Date of Birth: _____

By signing this form, I authorize the release of confidential health information about me to: Vestibular Therapy Specialists (fax number: 855-564-1831):

Provider Name: _____

Clinic Name: _____

Phone Number: _____ Fax Number: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnosis, and/or treatment. I understand I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. This request will expire in 120 days.

PLEASE RELEASE:

☐ All medical records including radiologic images including hospital reports, lab reports, treatment records, history and physical reports, pathology reports, care plans, progress notes and operative reports.

☐ Please only release the following:

_____

_____

_____

Patient Signature: _____ Date: _____