Medical Records Release Form

By signing this form, I authorize the release of confidential health information about me to Vestibular Therapy Specialists.

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 of drug or alcohol abuse, mental illness or communicable disease including HIV and AIDS.

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.

PLEASE RELEASE:

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

[ ] Only radiologic images and reports

[ ] Medical records only

[ ] DO NOT release my medical records to Vestibular Therapy Specialists

Signature of Patient _____

Power of Attorney or Guardian Signature: _____

Date:_____

This request will expire in 120 days