



Medical Records Release Form to Vestibular Therapy Specialists

Patient name: _____

DOB: _____

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

Release of information from:

Provider name: _____

Clinic name: _____

Phone: _____

Fax: _____

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:

Signature of Patient _____

Power of Attorney or Guardian Signature: _____

Date: _____