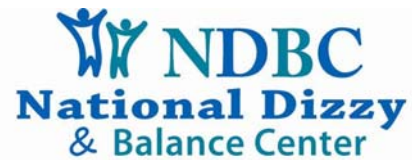


NDBC Edina Clinic
3400 W 66TH Street, Suite 300
Edina, MN 55435
Phone: (952) 345-3000
Fax: (952) 345-6789



**PATIENT'S AUTHORIZATION
TO RELEASE MEDICAL INFORMATION**

NAME: _____
(Patient's name)

ADDRESS: _____

DOB: _____

Home Phone: _____

THIS WILL AUTHORIZE:

TO RELEASE INFORMATION TO:

National Dizzy and Balance Center
3400 W 66th Street, Suite 300
Edina, MN 55435
Fax: (952) 345-6789

I give permission to National Dizzy and Balance Center to release the medical information indicated below, as part of the medical records maintained while I am/was a patient at the above facility during the period from _____ to _____.

PLEASE SEND:

- Complete Records (History & physical exams, doctor consultation reports, lab reports, and discharge summary)
- Complete Diagnostic Studies (VNG, ENG, audiology reports, Computerized Dynamic Posturography, and evoked potentials studies)
- Complete X-ray, MRI, and/or CT Reports (all films will be returned promptly)
- Physical Therapy Evaluations and Daily Notes
- Other: _____

THE INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE(S):

- | | |
|---|---|
| <input type="checkbox"/> Continuation of Medical Care | <input type="checkbox"/> Insurance Change |
| <input type="checkbox"/> Consult/Second Opinion | <input type="checkbox"/> Insurance Claim Report |
| <input type="checkbox"/> Personal | <input type="checkbox"/> Disability |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Other (specify) _____ |

I understand that this authorization will be in effect for 12 months from the date signed, unless the provider receives a cancellation by me in writing.

(Signature of Patient/Authorized Representative)

(Date – must be filled in)

If authorized representative, please sign and attach copies of supporting legal documentation.

(For authorized representative, please state relationship and reason patient unable to sign)