Center for Dizziness and Imbalance

5 N Maple Avenue, Suite 100
La Plata, Maryland 20646
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First visit
Annual update

Authorization to Release Information

Patient's Name ______________________ Today's Date ______________

I, the above named patient, hearby authorize Rocket Balance, LLC, to release and/or receive protected health information, including but not limited to diagnoses, health reports, test results, recommendations, and treatment guidelines for myself or the individual listed below.

Name ______________________ Date of birth ______________

I understand that these permissions may be revoked at anytime by notifying Rocket Balance, LLC in writing at the address listed above. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization form. Any revocation will not affect any actions taken before the receipt of the written revocation.

I further understand that this authorization will remain effective from the date of my signature for one full year. I understand that all information will be handled confidentially in compliance with all applicate state and federal laws.

If I have any questions, I understand that I am welcome to contact Rocket Balance, LLC at the above listed phone number.

______________________ ______________

Signature of patient/guardian Date

______________________ ______________

Signature of witness Date