CALIFORNIA EAR INSTITUTE

Release of Medical Records

Patient Information

Patient Name: ________________________________ DOB: ________
(Last Name) (First Name)
Address: ____
City: ______________________________ State: ______ Zip: ________

Release To / Request From

I authorize CEI Medical Group to Release / Request Medical Records

Release To: ☐

Request From: ☐

Person/Organization: ____
Address: ____
City/State/Zip: ____
Phone: _______________________ Fax: ____________________________

Purpose

For the following:

____Continuing Care
____ Insurance
____ Legal
____ Personal
____ Other: _______
____

Fees
You may pay by check, debit card, Visa or Mastercard

Our office will be happy to assist you in obtaining your records. The fees are as follows:

__**Fax medical records to patient or physician $25.00**
(Fax is only for less than 25 pages)

__**Mail medical records to physician or medical facility $30.00**

__**Medical records to patient $35.00**
(Mailed or Pic ked up by patient)

__**X-rays (each) and CT Cd $35.00**

***Please allow 48-72 hours for records to be completed**

Information to Release

Treatment Dates: ____________________________

___ **Entire Record**
___ **X-ray**
___ **Discharge Summary**
____**Operative Report**
____ **Laboratory Report**
____ **Other (Please Specify)**
____

___ **Audiology Testing**
___ **Cochlear Mappings (Please provide e-mail address to physician)**

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I may revoke this authorization at any time, but I must do so in writing. This authorization will automatically expire 180 days from this date, unless otherwise specified: ______________________________________

Signature: ______________________________________ **Date:** ______________
Relationship to Patient: ____________________ **Phone #** ____________________

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