CEI Medical Group
ear • sleep • sinus • face

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
___ Audiology Testing
___ Cochlear Mappings (Please provide e-mail address to physician)
____Operative Report
____ Laboratory Report
____ Other (Please Specify)
_____

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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