



California Ear Institute (CEI)

California Sinus Institute (CSI)

California Face & Laser Institute (CFI)

Let Them Hear Foundation (LTHF)

Authorization for Release of Medical Records

from CEI/CSI/CFI/LTHF

to CEI/CSI/CFI/LTHF

to AND from CEI/CSI/CFI/LTHF

Patient Information

Patient Name: _____ D.O.B.: _____

Address: _____ Phone: _____

Information To Be Disclosed

Complete health record(s)

Or the following individual types of information:

- Chart notes
- Radiological report(s)
- Hearing aid settings/verification
- Speech / Language Therapy
- Electrophysiologic tests/results/reports
- Consultation/other (please specify) _____
- Audiology test results
- Laboratory test(s)
- Cochlear implant maps
- Auditory Verbal Therapy

Range of Dates of Treatment

All or From (date) _____ to (date) _____

Disclose To/From

NAME _____
ADDRESS _____
PHONE/FAX _____

NAME _____
ADDRESS _____
PHONE/FAX _____

NAME _____
ADDRESS _____
PHONE/FAX _____

Disclose To/From CEI/CSI/CFI/LTHF Facility

PALO ALTO
1900 University Avenue, Suite 101
E. Palo Alto, CA 94303
Telephone (650) 494-1000
Fax (650) 322-8228

SANTA ROSA
196 Sotoyome Street
Santa Rosa, CA 95405
Telephone (707) 528-0565
Fax (707) 528-6403

SAN RAMON
5801 Norris Canyon Road, Suite 200
San Ramon, CA 94583
Telephone (925) 830-9116
Fax (925) 866-1699

Release

I hereby authorize the above disclosure of information. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition, or one year from the date of this agreement if a date, event, or condition is not specified:

Signed: _____ Date: _____

Name: _____

Title Patient / Parent / Legal Guardian

If legal guardian, please state relationship to patient and attach a copy of the conformed court guardianship

Witness: _____ Date: _____

Name: _____