



Medical Records Release

Date of request: _____

Patient's Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient's SSN: _____

When was the previous test done? _____

What was the name of the physician ordering the previous test?

I, _____ request that my medical records be released from _____, to The Center of Imaging Excellence, 2003-A Whitesburg Drive, Huntsville, AL, 35801. Phone: 256-536-3550 Fax: 256-536-3554

Signature of Patient/Gaurdian: _____

Date: _____

CIE Employee: _____