RELEASE OF INFORMATION

PATIENT INFORMATION

Patient Full Name: ______________________ **Date of birth:** ____________

Address: ______________________ **Phone:** ____________

ORGANIZATION AUTHORIZED TO REQUEST RECORDS

Organization Name: Sequoia Integrative Medical Records

Contact Person: Josie Lenz, Admissions Manager **Phone:** (920) 372-4168

Email: admissions@sequoiaintegrativemedicalservices.com **Fax:** (920) 543-5228

HEALTHCARE PROVIDER HOLDING THE RECORDS

Provider / Facility Name: ______________________

Address: ______________________

Phone: ______________________ **Fax:** ____________

INFORMATION TO BE REQUESTED

☐ Complete Medical Record ☐ Lab Results ☐ Medication Records

☐ Office Visit Notes ☐ Imaging / Radiology Reports ☐ Billing Records

☐ Other: ______________________

Date range of records (if applicable): ___/___/___ to ___/___/___

PURPOSE OF REQUEST

☐ Continuing Medical Care ☐ Legal ☐ Personal Records ☐ Insurance / Claims

☐ Other: ______________________

AUTHORIZATION

Option 1 – Patient Authorization

☐ I am the patient and authorize the release of my medical records as described above.

Patient Name: ______________________

Patient Signature: ______________________ **Date:** ____________

Option 2 – Authorized Representative (Family / Legal Guardian)

☐ I am authorized to act on behalf of the patient and I give permission to request the patient's records.

Representative Name: ______________________

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ POA ☐ Next of kin ☐ Other: ____________

Representative Signature: ______________________ **Date:** ____________

Revised 04/06/2026