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