

Request for Release Of Medical Records
From IMC

This information will be released from:
(please indicate **each IMC** provider that you are requesting records from)

Provider(s):

**The Integrative Medical Clinic of Santa Rosa
175 Concourse Boulevard
Santa Rosa, California 95403**

Send records to: _____

Address: _____

City, State, Zip: _____

Telephone or Fax: _____

Patient's Name: _____

Patient's D.O.B.: _____ SSN _____

Please send/release the following information:

- Complete Medical Records
- Test Results
- X-Ray Report
- Other _____

Signature: _____ Date: _____
Of Patient or Authorized Representative

Witness: _____ Date: _____

This authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires 90 days from the date of signing.

Enclose \$ 25 fee to cover the cost of preparing records for transfer and for postage. Records will be sent on receipt of fee.