

# Medical Records Release Form



Please provide the names and phone numbers of any providers who may have treated you for the condition related to your grievance. If there is more than one provider, please fill out a form for each one.

To get more copies of this form, call California Health & Wellness Member Services at **1-877-658-0305** (For TTY, contact **California Relay by dialing 711 and provide the 1-877-658-0305 number**) or go to [www.CAHealthWellness.com](http://www.CAHealthWellness.com).

**All medical records we receive will be held in strict confidence. We will only use it to review your grievance.**

Provider Name: \_\_\_\_\_ Provider Phone Number: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize and request  
(Member Name)

the above listed provider to release any and all medical records to California Health and Wellness that support medical necessity for:

(Please state service(s) that was denied or changed by California Health & Wellness)

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Sign Here > \_\_\_\_\_

Signature of Member or Authorized Representative      Date

\_\_\_\_\_  
Print Name of Member or Authorized Representative

\_\_\_\_\_  
Relationship (If signed by someone other than the member)

**DIRECTIONS:** Please fax this form to: **1-855-460-1009** or mail it to: California Health & Wellness, Attn: Appeals and Grievance Coordinator, 1740 Creekside Oaks Drive, Suite 200, Sacramento, CA 95833.