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**; **TDD/TTY 1-866-247-6083** or go to 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 the above listed provider
(Member Name)
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)

_____

_____

_____

_____

_____

_____

_____

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.