

**RECORDS RELEASE AUTHORIZATION**

To (Provider/Address):

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I hereby request your office to release all records regarding my care and condition pertinent to your treatment of me from

\_\_\_\_\_ to \_\_\_\_\_ including:

- History, findings, diagnosis, prognosis
- Radiographic studies and reports including X-Ray, CT, MRI to:

**Springtime Health and Wellness**

Jamie Lenz, DC, CCSP<sup>®</sup>, CACCP

Tracie Schmidt, PA-C

1001 S Whitney Way

Madison WI 53711

Telephone: (608) 274-6200

Fax: (608) 278-4586

I also request the Dr. Lenz, DC and/or Tracie Schmidt, PA-C to be able to contact the following providers regarding my care and condition:

\_\_\_\_\_  
(List names of providers)

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Patient (or Representative) Signature

\_\_\_\_\_  
Relationship (if Representative)

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Today's Date