Progressive Medical Associates, PLLC
13220 Rosedale Hill Avenue
Huntersville, NC 28078
Phone: 704-766-0320 Fax: 704-766-0407

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient: _____ D.O.B. _____

Social Security Number: _____

I hereby request that my Medical Records be released to my Primary Care provider as follows:

Progressive Medical Associates, PLLC
13220 Rosedale Hill Avenue
Huntersville, NC 28078
Fax: 704-766-0407

Information to be disclosed:

□ Complete Medical Record

OR

□ Progress Notes
□ Diagnostic Records Pertaining to _____
□ Lab Results
□ X-ray Reports
□ Hospital Records of Admission on _____
□ Other: _____

I understand

- This authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.
- Authorization for disclosures shall not condition treatment, payment, or eligibility for benefits. I may refuse to sign this authorization.

_____ _____
Signature of Patient (or Patient's Representative Date

_____
Relationship of Representative to Patient
(if signed by someone other than the patient)