



*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 Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I hereby authorize Progressive Medical Associates, PLLC to release my Medical Records to the following individual/entity:

Name	Telephone
Address	Fax Number
City State Zip Code	

Information to be disclosed:

Complete Medical Records

OR

- Progress Notes
- Lab Results
- Diagnostic Test Results
- Medication Lists
- 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.
- This protected health information may be re-disclosed by the recipient and no longer protected by HIPAA.
- This facility, its employees, and physicians are released from all legal responsibility/liability for the release of this information to the extent indicated and authorization herein.

\_\_\_\_\_  
Signature of Patient (or Patient's Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient  
(if signed by someone other than the patient)