*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: Progressive Medical Associates, PLLC
13220 Rosedale Hill Avenue
Huntersville, NC 28078

Information to be disclosed:

□Complete Medical Records
□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. Refer to Notice of Privacy Practices for details.
- Authorization for disclosures shall not condition treatment, payment, or eligibility for benefits. I may refuse to sign 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 Representative Date

_____
Print Name

_____
Relationship of Representative to Patient