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

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient (Last, First): __________________________________ Date of Birth: ___________

Social Security Number: ________________________

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

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Huntersville, NC 28078
Phone: (704) 766-0320
Fax: (704) 766-0407

<u>Information to be Disclosed</u>:

□ Complete Medical Record

OR

□ Progress Notes
□ Mental Health Records
□ Diagnostic Records Pertaining to ____
□ Lab Results
□ X-ray Reports
□ Hospital Records of Admission for Dates: _____________to_____________
□ 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	Date
___________________________________	___________________________________
Printed Name of Patient Representative (If signed by someone other than the patient)	Relationship of Patient Representative