Progressive Medical Associates, PLLC

FAMILY & FRIENDS AUTHORIZATION

Name of Patient (Last, First): _____Date of Birth: _____

This form does not give the people listed below the right to access medical information or medical records.

This form documents my request to allow family members and/or friends to be involved in **verbal** discussions regarding my healthcare. The people listed below may receive any **verbal** information needed to participate in my care, or to help me make decisions. By signing this form, I permit staff at Progressive Medical Associates, PLLC to discuss information about me with the people listed below. This information may include diagnoses, test results, treatment options and other information from previous clinic services.

- I understand that signing this form is voluntary and that my healthcare information may be released to family members or friends listed. Electing not to sign will in no way impact the care I am given.
- I understand that listing people on this form does not give them the right to access, receive, or copy my medical records and that this authorization is limited to verbal and telephone conversations, only.
- I understand that listing people on this form does not allow them to consent for healthcare services on my behalf.

NAME	PHONE	RELATIONSHIP

I may update or revoke this form at any time by completing a new form and providing it to an office staff member, or forwarding it to the following address. Additionally, I may revoke this form at any time by submitting a written notification to an office staff member or by forwarding my notification to the above address.

Progressive Medical Associates, PLLC
13220 Rosedale Hill Ave.
Huntersville, NC 28078

_____ _____
Signature of Patient Date

_____ _____
Printed Name of Patient Representative
(If signed by someone other than the patient)
Relationship of Patient Representative