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
□ Progress Notes
□ Lab Results
□ Diagnostic Test Results
□ Consult Notes
□ 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. Refer to Notice of Privacy Practices for details.
- 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.

Patient / Responsible Party _____ Date: _____
Please Print

Patient / Responsible Party Signature:_____