Progressive Medical Associates, PLLC

Authorization for Release of Information to Family and/or Friends

Name of Patient:_____**Date of Birth:**_____

Do you authorize Progressive Medical Associates to release protected health information to your SPOUSE / PARTNER?

☐ **Yes** ☐ **No** ☐ **N/A**

If Yes:

Name of spouse/partner: _____

Which types of information do you authorize your spouse / partner to receive:

☐ **Medical Information**

☐ **Financial / Billing**

Do you authorize Progressive Medical Associates to release protected health information to any other FAMILY MEMBERS OR FRIENDS? If Yes, provide the information below:

Name	*Relationship to You*	*Phone Number*	*Type of Information*
			☐ **Medical** ☐ **Financial**
			☐ **Medical** ☐ **Financial**
			☐ **Medical** ☐ **Financial**

_____

I understand that I have the right to revoke this authorization at any time by sending a written notification to Progressive Medical Associates. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective immediately upon receipt of written notification by this practice. I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization.

_____ _____

Signature of Patient (or Patient's Representative) Date

_____

Relationship of Representative to Patient
(*if signed by someone other than the patient)*