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: _____ Phone Number: _____

I hereby authorize Progressive Medical Associates, PLLC to release my Medical Records to the following individual/entity:

Name:	
Telephone:	**Fax Number:**
Address:	
City, State, Zip Code:	

Information to be disclosed:

□ Complete Medical Records
□ Patient Portal Access & Information

OR

□ Progress Notes
□ Lab Results
□ Diagnostic Test Results
□ 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 regards to 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 Date

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