PROGRESSIVE MEDICAL CLINIC, LLP
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME_____
Last Name First Name Middle Initial

HOME ADDRESS_____
Street Address

_____
City State Zip Code

_____
Date of Birth

I hereby request_____

_____
Street Address

_____
City State Zip Code

_____
Phone Number Fax Number

To furnish a copy of <u>ALL Available Medical Records</u> of the patient named above to Progressive Medical Clinic.

Purpose or Need for Disclosures: Continued Patient Care

_____ I authorize the release of all information, including information regarding HIV testing, AIDS information, substance abuse, alcohol use, psychiatric disorders and psychological disorders that may be included in my medical record. I hereby release your physician and staff from liability following this authorization and release.
Initials

_____ _____
Signature of Patient/Parent/Conservator/Guardian Authority/Relationship to Patient

_____ _____
Witness Signature Date