

PROGRESSIVE MEDICAL, INC.
AUTHORIZATION FORM FOR USES AND DISCLOSURES OF PATIENT INFORMATION

PATIENT INFORMATION

Patient Name:	Social Security No.	
Date of Birth:	Date of Injury:	
Street Address:		
City:	State:	Zip:

INFORMATION TO BE USED OR DISCLOSED

Please disclose the following protected health information:
<input type="checkbox"/> Medication list/prescriptions <input type="checkbox"/> Itemized Billing Statements <input type="checkbox"/> Patient records and notes <input type="checkbox"/> Entire Record <input type="checkbox"/> Other: (explain)
Specify dates or date ranges if applicable:
The information is being disclosed for the following purposes:

REQUESTOR/RECIPIENT INFORMATION

This information may be disclosed to and used by the following person/organization:		
Name:		
Street Address:		
City:	State:	Zip:
Unless otherwise revoked, this authorization will expire in six months or on the following date:		

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the Compliance Officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

NOTE TO AUTHORIZED REPRESENTATIVES: If an Authorized Representative is signing this form on behalf of the patient, additional documentation supporting the authorization to disclose patient information, such as a Power of Attorney for healthcare, must be submitted in order for records to be provided.

Signature of Patient or Authorized Representative:	Date:
Relationship of Personal Representative to Patient or Statement of Authority: (if applicable)	

SUBMIT THIS FORM TO ADDRESS BELOW, OR FAX TO 614-212-8008

Progressive Medical, Inc. Attn: Medical Records
250 Progressive Way
Westerville, OH 43082