

**PROGRESSIVE MEDICAL, INC.
 REVOCATION OF AUTHORIZATION FOR USE AND DISCLOSURE OF
 PROTECTED HEALTH INFORMATION**

Revocation of Authorization:

This notice revokes the authorization to the use and disclosure of protected health information for:

Patient Name:		Social Security No.	
Date of Birth:		Date of Injury:	
Street Address:			
City:		State:	Zip:
Date of Consent on Authorization: (or attach a copy)			

Effect of Revocation:

Protected health information collected on or after the date on which this form is received by Progressive Medical, Inc. will not be used or disclosed by Progressive Medical, Inc. for the purposes specified in the revoked authorization.

This revocation of authorization will not limit the ability of Progressive Medical, Inc. to seek payment for services that it provided under an earlier authorization, nor to meet legal obligations related to those services. The revocation also will not affect uses or disclosures that occurred prior to the effective date of this revocation.

Effective Date of Revocation:

Please indicate the effective date of the revocation of authorization to use or disclose protected health information:

- Immediately
- Other. (Please specify)

Name of Patient (print):			
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
 Fax: (614) 212-8008