

Progressive Healthcare Group
 300 S Ocotillo - P.O. Box 1819
 Benson, AZ 98602
 Phone: 520-586-9111 Fax:520-586-9091
REQUEST FOR RELEASE OF MEDICAL RECORDS

I Authorize Progressive Healthcare Group to release protected health information from the records of:

Patient Name:

Date of birth:

Address:

Phone:

SS#:

MR#:

Covering periods(s) of health care from (date)_____ to (date)_____

This information is to be released **TO: NAME**_____

Address:_____ **Phone/fax:**_____

Information to be disclosed: Complete written record or selected information as checked.

<input type="checkbox"/>	Complete written record	<input type="checkbox"/>	Procedures Reports
<input type="checkbox"/>	Discharge summary	<input type="checkbox"/>	Progress notes
<input type="checkbox"/>	History & physical	<input type="checkbox"/>	Laboratory tests
<input type="checkbox"/>	Consultation	<input type="checkbox"/>	X-rays
<input type="checkbox"/>	Other (please specify)		

I Understand that this may include information relating to the following and I agree to its release unless I indicate **NO**.

- Yes**_____ **No**_____ Aids (infection)
Yes_____ **No**_____ Behavioral Health Care
Yes_____ **No**_____ Treatment for alcohol/drug abuse
Yes_____ **No**_____ Genetic Counseling testing

I understand this information may be revoked in writing at any time, except to the extent that action has been taken based upon authorization.

Signature of Patient or Legal Representative:_____

Printed Name Patient or Legal Representative:_____

Relationship to/or authority to act for Patient:_____

Signature of witness:_____ **Date:**_____