Progressive
MEDICAL CENTER

Authorization of Medical Release

Date _____

Patient Name _____ **Date of Birth**_____

SSN# _____

I am a current/ former patient of _____

I authorize and request that you send a copy of my medical records to:

Name _____

Address _____

City, State, Zip _____

Phone number _____ **Fax** _____

E-mail_____

Records to send_____

I Authorize my records to be sent via (choose one): ☐ **Email** ☐ **Mail** ☐ **Fax**

This clinical information will be regarded as confidential and privileged and will be used solely for patient management.

Witness_____ **Patient**_____
Signature **Signature**

Witness_____ **Patient** _____
Print Name **Print Name**

Please be advised that records requests have a turn-around time of up to 2 weeks and will be processed through Chart Pro.

Charges for records requests are as follows:

Up to 20 pages--Free

20 to 50 pages--$25

50 to 100 pages--$30

100 plus pages--$40

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