Progressive Therapy Associates
improve. empower. renew.

1150 Prairie Parkway, Suite 105
West Fargo, ND 58078
Phone: 701-356-7766
Fax: 701-356-7765

Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth: _____

Phone Number: _____ Address: _____

❑ I authorize ***the following*** to release records to Progressive Therapy Associates:
❑ I authorize Progressive Therapy Associates to release records ***to the following***:

Other Entity: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Information to be disclosed:

- ❑ Therapy Progress Notes from _____ to _____
- ❑ Verbal (phone) and Written (Email or fax) Communication
- ❑ Doctor's Medical Notes _____ to _____
- ❑ X-ray Reports
- ❑ Other _____

For the purpose of:

- ❑ Education
- ❑ Further Treatment
- ❑ Payment of Insurance Claims
- ❑ Legal
- ❑ Other _____

❑ Yes ❑ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I understand that I may revoke this authorization in writing at any time, except to the extent action had already been taken. If not previously revoked, this authorization will expire in twelve months. A photocopy or fax of this authorization will be treated in the same manner as the original.

Patient Signature: _____ Date: _____