HealthSpot

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT FIRST NAME	M.I.	PATIENT LAST NAME
PATIENT D.O.B.		TELEPHONE NUMBER

AUTHORIZATION IS GIVEN BY THE UNDERSIGNED TO RELEASE THE INFORMATION SPECIFIED BELOW:

Name of Entity to RELEASE information:

Name: ProgressiveHealth HealthSpot, LLC

Address: 9000 Greenbrier Parkway NW, Unit # 84

Madison, AL 35756

Name of Entity or Person to RECEIVE information:

Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

Email: _____

SERVICE DATES:

☐ All dates of service

☐ Specific range - from _____ to _____
Date Date

INFORMATION TO BE RELEASED:

☐ Entire record
☐ Occupational Health Visit Records
☐ Audiology Results
☐ Vision Screening Results
☐ Non-Occ Health Visit Records
☐ Drug Screening Results
☐ Breath Alcohol Testing Results
☐ Other (please specify):_____

THE INFORMATION IS REQUESTED FOR THE FOLLOWING PURPOSE:

☐ Employer required testing/screening
☐ Insurance
☐ Other (please specify):_____
☐ Legal Purposes
☐ Treatment/Continuing Care

RELEASE THESE RECORDS VIA : □ In Person □ Mail (□ paper or □ CD*) □ Fax □ Email*

**Note that records sent via email or CD will be encrypted.*

- I understand that this authorization can be revoked by me at any time, except to the extent information has been released in reliance upon this authorization, by submitting a written request to ProgressiveHealth HealthSpot, LLC at the address listed above.
- I understand that the material released as a result of the authorization may be subject to redisclosure and no longer protected by the laws applying to medical information release.
- I understand that the facility releasing the records cannot require my signature on this document as a condition for providing treatment, obtaining payment, enrollment or eligibility for benefits (if applicable) except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
- This authorization will expire sixty (60) days after it is signed unless otherwise specified as follows: _____.

SIGNATURE OF PATIENT	DATE OF SIGNATURE
SIGNATURE OF OTHER AUTHORIZED PERSON	RELATIONSHIP TO PATIENT

8-2025