RELEASE OF MEDICAL RECORDS CONSENT FORM

The patient/guardian/parent singed and dated below agrees to have the following records released to Progressive Physician Associates (PPA) Health and Wellness for the purposes of medical treat.

Patient Name _____

DOB _____

SSN _ _ _/_ _/_ _ _ _ Date _ _/_ _/20_ _

___ All Records

___ Specific Records

_____

_____

_____

Progressive Physician Associates (PPA) Health and Wellness

__ Dr. Naja Thomas
__ Dr. Carl Middleton

4400 Heritage Trace Parkway
Suite 204
Ft. Worth, TX 76244
Phone: 800.334.0150
Fax:

The patient/guardian parent signed and dated below agrees to have the following records released to:

Physician (Office) _____

Facility _____

for the purposes of medical treatment.

PATIENT'S SIGNATURE_____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).