Evolution Medical Associates

604 Druid Rd. E. Clearwater, FL 33756   727-216-3492

I, ____ hereby give consent for agents of Evolution Medical Associates LLC to release specified information to and discuss issues regarding me with the below listed people and entities:

Name: ____

Phone:__________________________________ Fax ___________________________________

E-mail ____

Name: ____

Phone:__________________________________ Fax ___________________________________

E-mail ____

Name: ____

Phone:__________________________________ Fax ___________________________________

E-mail ____

I understand that e-mail communications are vulnerable to compromise of their confidentiality. Despite the risk of loss of confidentiality, for the sake of convenience, I agree to allow transmission of my information by e-mail. I further understand that billing information will not be transmitted by e-mail.

I do _____ agree with the above. __________ Initial

I do not _____ agree with the above. __________ Initial

Signed:____

Date ________/________/_________