Evolution Medical Associates

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

AUTHORIZATION for RELEASE OF INFORMATION

for USE, COPYING, DISCLOSURE and INSPECTING of PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

DATE of BIRTH: _____ SOCIAL SECURITY NUMBER: _____

1. I hereby authorize _____ (hereinafter "Medical Provider") to use, copy, disclose or allow inspection of protected health information about me as described below. A photocopy of this authorization is as valid as an original.

2. The information to be disclosed is for all dates of service requested and includes:
   _____ Complete medical records, including but not limited to, office notes, progress notes, procedure notes, operative reports, intake questionnaire and patient history form
   _____ Physical therapy records _____ Massage therapy records _____ Billing records
   _____ Benefits information, incl health insurance, workers' compensation, Medicare, Medicaid, and disability coverage
   _____ Other: _____

3. I understand that the records used and disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse: or mental or behavioral health or psychiatric care.
4. I understand that copies of the records indicated above may be sent to my attorneys, _____ as said records are needed to assist in their representation on my behalf.
5. I understand that the information used or disclosed may be subject to re-disclosure by the Law Office of _____ and would then no longer be protected by federal or state privacy regulations.
6. I understand that I may revoke this authorization by notifying the Medical Provider in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
7. Unless otherwise revoked, I understand that this authorization expires on _____.
8. I understand that the Medical Provider may not condition treatment on my completion of this authorization form.
9. I understand that the Medical Provider may charge a fee for the costs of copying, mailing or supplying the requested information.

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

_____ _____ _____

Printed Name **Printed Name** **Printed Name**

_____ _____

Signature of Patient or Parent, Guardian or Personal Representative **Date**