REQUEST FOR RECORDS

I give EVOLUTION REHAB GROUP permission to request my medical records from the following providers.

Please securely fax records back to:
EVOLUTION REHAB GROUP
www.evolution.rehab
P-561-900-2423 Ext 1
F-561-600-3011

Provider:_____

Practice/Facility Name:_____

Phone:_____

Fax:_____

Approximate Date(s) of Service / Specific Records:_____
_____
_____
_____

Patient Name:_____ Signature:_____

DOB:_____ Phone:_____

Date:_____