PERMISSION TO DISCLOSE MY RECORDS

I also will allow **Evolution Rehab Group** to send records to the following providers to help coordinate care as needed. I understand that once they transmit the records, there is no ability to ensure that the intended recipient is abiding with HIPAA and HITECH standards in ensuring privacy and security of my disclosed records at all times, and absolve **Evolution Rehab Group** of any mishandling of my records once they have been sent. I also understand that **Evolution Rehab Group** will retain a log of any disclosure of my records. This also pertains to any written requests with your authorization from other providers that come to our office. Written request for records will be handled within 14 business days of the written request. The permission below will stand for the calendar year 2020, and can be revoked at any point with a written request.

NOTE: **Your referring physician will automatically be notified of the care plan and progress and is not needed to be listed here.**

Evolution Rehab Group
W- evolution.rehab
P- 561-900-2423 Ext 1
F- 561-600-3011
E- info@evolution.rehab

Please send authorize records requests from the following:

Provider:_____ Phone:_____ Fax:_____

Provider:_____ Phone:_____ Fax:_____

Provider:_____ Phone:_____ Fax:_____

Provider:_____ Phone:_____ Fax:_____

Provider:_____ Phone:_____ Fax:_____

Use this space if you wish to detail any specific parts of the episode of care to disclose or not disclose otherwise all aspects are eligible for disclosure.

_____

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Patient Name:_____ Signature:_____

Date:_____