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Date: _____

I authorize Clinical Neurosciences of Tampa Bay, LLP (CNS) to release my medical records to:

CNS is authorized to send the following to the above address or fax (check all that apply):

Copies of medical records
 Discharge summary from hospitalization
 Actual Films (x-ray, CT, MRI, or other imaging results)
 Dictated results of _____
 Other _____

Mail records to above address
 Fax records to (fax number) _____
 I will pick up the records from the CNS office

Patient Signature: _____

Patient Printed Name: _____

Patient Date of Birth: _____

Patient Social Security Number: _____

Witness Signature _____

Confidential fax! The personal health information contained in this transmission is highly confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to the patient. Any other use is a violation of Federal law (HIPAA) and will be reported as such.

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