

**PATIENT RELEASE OF MEDICAL RECORDS TO CNS**

Date: \_\_\_\_\_

I authorize \_\_\_\_\_ to release my  
(Name of sending doctor or practice)  
medical records to:

Dr. \_\_\_\_\_  
Clinical Neurosciences of Tampa Bay, LLP  
430 Morton Plant Street, Suite 400  
Clearwater, FL 33756  
Fax (727)446-4336  
Phone (727)443-3295

Please fax or mail the following to Clinical Neurosciences of Tampa Bay, LLP at the above fax number or physical address (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 \_\_\_\_\_

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.

If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copy of this communication is strictly prohibited. If you have received this communication in error, please notify our office immediately.