CLINICAL NEUROSCIENCES OF TAMPA BAY  
430 Morton Plant Street, Suite 400  
Clearwater, FL 33756  
Phone (727)443-3295 Fax (727)446-4336  
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**PATIENT RELEASE OF MEDICAL RECORDS**

Date:   
  
**From CNTB:**  
I authorize Clinical Neurosciences of Tampa Bay, LLP (CNTB) to release my medical records to:  
Fax # for requesting doctor facility:  
  
Address of requesting doctor or facility:  
  
  
 **Please note charges may apply for records if we are releasing to the patient. There will be no charge to fax records to another office. First 5 pages free, $1.00 per page up to 25, and .25 cents every page after.**

CNTB is authorized to send the following to the above address or fax   
 Copies of medical records  
 Discharge summary from hospitalization  
 Actual films (x-ray, CT, MRI, or other   
   
   
**To CNTB:**

I authorize\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to release my  
medical records to (List Doctor or Practice):

Dr:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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)  
 Other

Imaging results) \_\_ 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 (HIPPA) 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.