Clinical Neurosciences of Tampa Bay
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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 Number for the requesting Doctor or 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 that.

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

__ Copies of medical records
__ Discharge summary from hospitalization
__ x-ray, CT, MRI, or other Imaging results

__ Other

Patient Signature: _____

Patient Printed Name:_____

Patient Date of Birth:_____

Witness Signature:_____