



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: _____

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.

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