**PATIENT RELEASE OF MEDICAL RECORDS**

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

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

Clinical Neurosciences of Tampa Bay, LLP \_\_ Dr. Patel 1417 S Belcher Road Unit C \_\_Dr. Pollock
Clearwater, FL 33764 \_\_Dr. Arora
Fax (727)446-4336 \_\_Dr. Cabello
Phone (727)443-3295 \_\_Ashmia Bahl ARNP

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
 \_\_\_ Xrays, CT, MRI, Etc
 \_\_\_ Any Testing

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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