**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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