

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO :

Hospital, Physician's / Group Name

Address

City

State

Zip Code

I hereby request that my medical records be released to:

***Tampa Neurology Associates/Axiom Clinical Research of Fla.
2919 Swann Ave Suite # 105A
Tampa, Florida 33569***

Attn: Axiom Clinical Research

Ph # 813-353-9613

Fax # 813-353-9169

Date _____

Patients Name

Birthdate

Social Security #

FULL AND COMPLETE MEDICAL RECORDS CONCERNING

Signature : _____

Witness Signature : _____