



**Florida Center**  
*for Headache & Neurology*

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**MEDICAL RECORD RELEASE**

I, \_\_\_\_\_, D.O.B.: - - ,SS# - -

Hereby authorize \_\_\_\_\_ to  
release information to Dr.Conidi, pertaining to my medical treatment.

I, hereby give my consent for Dr.Conidi to speak with

Dr \_\_\_\_\_ via phone or in person,  
pertaining to my medical treatment, condition, etc.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please fax the following Documents:

- Office Notes
- MRI/A Reports
- EEG Reports
- EMG Reports
- Labs
- Hospital Records
- Cardiac Testing
- All of the above
- Other

