Records Release

To: _____

_____

_____

_____

I hereby authorize: Cardiac Arrhythmia Institute, LLC

Copy or Summary of:

_____
_____
_____
_____
_____

Concerning my illness and/or treatment during the period from:

_____ to _____

Patient's Name: _____ DOB: _____

Signature: _____ Date:_____

Witness & Relationship of Witness:

_____

**** This authorization will expire in 12 months from the date of this signature****

www.caiaz.com
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Phone 480.889.1573 Fax 480.889.1574