C.A.I
A Cardiovascular & Arrhythmia Institute

Records Release

To: ___________________________________

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I hereby authorize: Cardiac Arrhythmia Institute, LLC

Copy or Summary of:

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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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