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CLINICAL CARDIAC ELECTROPHYSIOLOGY
COMPLEX ARRHYTHMIA ABLATION
AND CARDIAC DEVICES

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Authorization for Use/Disclosure of Information:

Authorization for OsciDisciosure of Information.	
I authorize my health care information to be released to the following recipient(s):	
Cardiac Arrhythmia Institute	
Phone: 800.771.7164	
Fax: 800.773.7581	
Purpose: I authorize the release of my health information for the following specific purpose:	ose:
Continuation of care	
<u>Information to be disclosed:</u> I authorize the release of the following health information applicable box below)	tion: (check the
☐ All of my health information that the provider has in his or her possession, including	ing information
relating to any medical history, mental or physical condition and any treatment received by	me.1
☐ Only the following records or types of health information:	
Signature	
Date	