



Cardiology & Arrhythmia Consultants, Inc.

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To: _____

Re: _____

I hereby authorize and request you to release to Cardiology & Arrhythmia Consultants, Inc., my complete medical record regarding my illness and/or treatment.

I hereby authorize and request all medical personnel and hospitals if requested by Cardiology and Arrhythmia Consultants, Inc. to furnish to them all records, reports, and any other information that they may request regarding any examination, treatment, test, or opinion concerning any condition that I may have had, now or in the future.

Thank you for your assistance in this very important matter.

Signature

Date