PINELLAS ARRHYTHMIA ASSOCIATES, P.A.
516 Lakeview Rd. Villa 5 Clearwater, Fl 33756
Phone: 727 587-6999 FAX: **727 259-7818**

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Social Security #: _____

I hereby authorize _____ to furnish the following medical information and records: (*check all that apply*):

0 Office visits/pacemaker check/echocardiograms/consultations/history & physicals
0 Dr. _____ last note
0 Medical information as related to: _____
0 Records dated _____
0 Other _____for the purpose of: _____

0 I, hereby give Pinellas Arrhythmia Associates authorization to review my medication history.

This information is to be released to:

Pinellas Arrhythmia Associates
516 Lakeview Rd. Villa 5
Clearwater, Fl 33756

In addition to the information listed above, I authorize the release of the following (*initial if appropriate):*

0 Diagnoses and/or treatment for alcohol and/or drug abuse _____
0 Psychiatric or psychotherapeutic records _____
0 Sexually transmissible disease and HIV test results: _____

My refusal to sign this Authorization will not affect my ability to obtain treatment or payment. This authorization will remain in effect until: _____.

I understand the information released may be subject to re disclosure by the recipient. I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that the practice has already taken action in reliance on my authorization.

_____
Print Name of Patient

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If legal representative, print name Relationship to Patient