Yoel R. Vivas, M.D., F.H.R.S.
Luis F. Mora, M.D.
Mark Freher, M.D., F.A.C.C.
Alexandra Beaumont, A.P.R.N.
5258 Linton Blvd. Ste 106 Delray Beach, FL 33484
Phone: (561) 303-3491 Fax: (877) 248-5240

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth:____________________________

SSN: ____

I request and authorize ____ to release healthcare information of the patient named above to:

The Arrhythmia Center of South Florida –
5258 Linton Blvd. Ste 106 Delray Beach, FL 3348
Phone: (561) 303-3491 Fax: (877) 248-5240

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates:____________________________

  ____

- All healthcare information

- Other: ____

I place no restrictions on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, psychiatric disorders, or HIV infection.

Patient Signature: ____ Date Signed: _________________________