Arrhythmia Management Institute of South Florida

6705 Red Road, Suite 500, Coral Gables, FL 33143
Phone: 305 662-2530 | Fax: 305 663-2375 | www.amisf.com

John R. Dylewski, M.D., FHRS
Clinical Cardiac Electrophysiology & Cardiology

AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH FAMILY & FRIENDS

I, ______________________________________ am giving Dr. John R. Dylewski and the Arrhythmia Management Institute of South Florida permission to discuss my medical condition with the following family members and/or friends.

Name	Relationship	Phone Number
______________________________________	___________________	___________________
______________________________________	___________________	___________________
______________________________________	___________________	___________________
______________________________________	___________________	___________________

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Patient's Signature Date

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Name of Patient