AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

To Abington Medical Specialists (AMS Cardiology)

Patient Name:_____ **Date of Birth**: _____

I authorize my health care provider: Name: _____
Address: _____

To Release my health care information to:

Abington Medical Specialists Attn: Dr. _____
1235 Old York Road, Suite 222
Abington, PA 19001
Fax #: 215-376-1706

Information to be disclosed: I authorize the release of the following health information:

____ All of my health information including office notes, hospital summaries, test reports
____ Communications in my records from other physicians/consultants
____ List any specific items to be sent that are not covered by the above.

Special Authorizations for Release of Information of Mental Health/AlcoholDrugs/HIV/AIDS

*****Please initial each of these if applicable*****

PA Act 26: Please include any of my records for a diagnosis and/or treatment of alcoholism, drug abuse or dependency _____.

Federal Privacy Act (PL93-282) and the PA Mental Health Procedures Act: Please include records for a diagnosis or treatment concerning my mental health or rehabilitation _____.

PA Act 148 Confidentiality of information related to HIV/AIDS: Please include records for a diagnosis, testing, treatment of HIV/AIDS _____.

I also understand that I may revoke this authorization/consent (except to the extent that action has been taken in reliance thereon) at any time by written, dated communication.

Patient Signature: _____

Date: _____

Witness: _____

If the patient is unable to give consent because he/she is a minor or has a physical/mental condition, please complete the following required information:

Guardian Signature:_____ Date:_____

I hereby designate _____to claim my records on my behalf.

Pick up date: _____

Photo ID provided: Drivers License #: _____ Other ID: _____

Please specify