AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

I authorize my health care provider (Name)_____

To release my health care information to:
AMS Cardiology Attn: Dr. _____
118 Welsh Road
Unit B
Horsham, PA 19044
Fax#: 215-376-1705

I authorize the release of the following health information:

___Office notes, hospital summaries, test results

___Communication from other physicians/consultants

___List any specific items to be sent that are not covered above:

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

Patient Signature:_____

Date:_____

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.**