**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:

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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.**