

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

AMS Cardiology Locations

Main Office 118 Welsh Road, Unit B Horsham PA 19044 Levy Medical Plaza 1235 Old York Road,
Suite #110 Abington PA 19001 Montgomeryville Office 1010 Horsham Road Suite #214 North
Wales PA 19454 Horsham office 507 Prudential Road Suite 101 Horsham PA 19044 AMS
Cardiovascular ASC 507 Prudential Road Suite 101A Horsham PA 19004