



[www.amscardiology.com](http://www.amscardiology.com) 215.517.1000

### 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

**Montgomeryville Office:** 1010 Horsham Road Suite 214 North Wales PA 19454

**Horsham Office, Imaging, Rehab:** 507 Prudential Road Suite 101B Horsham PA 19044

**AMS Cardiovascular ASC:** 507 Prudential Road Suite 101A Horsham PA 1900