



# Abington Memorial Hospital

1200 Old York Road, Abington, PA 19001

## AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address: (Street, City, State)

(\_\_\_\_)\_\_\_\_-\_\_\_\_  
Phone (Area Code and Number)

I THE UNDERSIGNED AUTHORIZE ABINGTON MEMORIAL HOSPITAL (AMH) THE USE/DISCLOSURE OF HEALTH INFORMATION PERTAINING TO THE PATIENT NAMED ABOVE

I FURTHER AUTHORIZE THE USE/DISCLOSURE OF THE ABOVE NAMED PATIENT'S HEALTH INFORMATION TO THE FOLLOWING PERSON(S) AND/OR ENTITY

From:

To:

\_\_\_\_\_  
Please Print Name of Individual or Entity

\_\_\_\_\_  
Please Print Name of Individual or Entity

\_\_\_\_\_  
Address (Street Name and Number)

\_\_\_\_\_  
Address (Street Name and Number)

\_\_\_\_\_  
Address (City, State and Zip Code)

\_\_\_\_\_  
Address (City, State and Zip Code)

I ASK THAT ONLY THE FOLLOWING HEALTH INFORMATION BE USED OR DISCLOSED BY AMH

\_\_\_\_\_  
Please describe the health information for the above named patient to be used or disclosed (eg., Medical Records etc.)

I REQUEST THE USE AND/OR DISCLOSURE OF THE ABOVE NAMED PATIENT'S HEALTH INFORMATION FOR THE FOLLOWING PURPOSES:

\_\_\_\_\_  
If patient is requestor please write "at the request of the patient"

I understand that if the person or entity that receives my health information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. (Please see federal and state law prohibitions on redisclosure on reverse side of this form)

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.