

**Abington - Jefferson Health
Cardiothoracic Surgery**

1200 Old York Road
5 Toll, Heart and Vascular Institute
Abington, PA 19001
215-481-4200

Patient Name: _____

Date of Birth: _____

I authorize Abington - Jefferson Cardiothoracic Surgery to speak to the following person(s) with regard to my medical/billing information.

1. _____ 3. _____

2. _____ 4. _____

I decline to give authorization at this time.

**Patient
Signature:** _____

Date: _____