

RECORDS RELEASE AUTHORIZATION

Hospital or Entity

- Providence Hospital (202)269-7273/Phone (202) 269-7931/Fax
- Medstar Southern Maryland Hospital (301) 877-4524/Phone (301) 856-8969/Fax
- Medstar Washington Hospital Center (202) 877-7181/Phone (202) 877-5496/ Fax
- United Medical Center (202) 574-6521/Phone (202) 547-7098/Fax
- _____ () - /Phone () - /Fax

I hereby authorize and request you to release records to:

Leon L. Dawson, MD. FACC
Heart Masters Medical Associates

1647 Benning Road NE
Suite 103
Washington, DC 20002
Phone: (202) 399-0133
Fax: (202) 399-0132

7700 Old Branch Avenue
Suite B-205
Clinton, MD 20735
Phone: (301) 877-4933
Fax: (301) 877-6963

Records Requested

- EKG: ____/____/____ Echocardiogram: ____/____/____
- Hospital Visit Notes/ H& P: ____/____/____ Hospital consults: ____/____/____
- Cath: ____/____/____ Stress Test: ____/____/____ Labs: ____/____/____
- Discharge Summary: ____/____/____
- Other: _____: ____/____/____

Name of the patient: _____

SS number: _____

Date of Birth: _____

Address: _____

City, state, Zip: _____

Date: ____/____/____ Authorizing Signature of patient /Agent: _____