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Records Release Authorization

_________________________________ Patient's Full Name (Please Print)

_______________ Patient's DOB

_________________________________ Patient's Address

_______________ Contact Phone Number

I, _________________________________ authorize _______________

_________________________________ to release my medical records to include:

____ History & Physical ____ Progress Notes ____ Labs ____ Pathology Reports

____ List of medication ____ ER report ____ EKG / EEG/ ECG/ Cardiac Reports

____ Radiology Reports ____ All Records

Release Information to: _________________________________

1120 19th Street NW, Suite 200

Washington, DC 20036

202-296-0670 phone **202-331-8924 fax**

_________________________________ Signature of Patient

_______________ Date