Pediatric Cardiology of Maryland

James D. Telep, M.D., F.A.A.P., F.A.C.C.

Authorization to Release Medical Records

I hereby authorize:

Name: _____

(Physician, Hospital or Healthcare Provider)

Address: _____

Phone Number: _____ Fax Number: _____

To release my medical records including:

____ All my medical records ____EKG
____ Echocardiogram ____ Holter Monitor
____ Other: _____

Patient Name: _____

DOB: _____

To release my medical records to:

Pediatric Cardiology of Maryland
2024 West St. #304
Annapolis, MD 21401
443-598-2480 (Office)
443-598-2488 (Fax)

Signature: _____ Date: _____

Relationship to Patient: _____