CANCER AND BLOOD DISORDERS TREATMENT CENTER

M. Ashraf Meelu, MD FACP

Medical Records Release Form

I, _____hereby authorize:

_____

_____

_____

_____

To release my medical records to:
Cancer & Blood Disorders Treatment Center
M. Ashraf Meelu, MD FACP
3200 Crain Highway, Suite 302
Waldorf, MD 20603
301-638-1007
Fax 301-638-1009

Patient Signature: _____

Date: _____

D.O.B. _____

Witness: _____