Steven R. Bullard, M.D.

Record Release of Information

Patient Information:

Name _____ Date of Birth _____

Address _____

Signature _____ Date _____
If not patient, state relationship

Witness Signature _____ Date _____

OPTION 1:

( ) I, _____, hereby authorize my medical records to be released to:

Patient/Clinic Name: _____

Physician's Name: _____

Address: _____

Phone Number: _____ FAX Number: _____

OPTION 2:

( ) I, _____, hereby authorize _____ to release my medical records to:

Steven R. Bullard, M.D.

44121 Harry Byrd Highway, Suite #205

Ashburn, VA 20147

Phone: 703-370-2455 Fax: 703-641-4841

Processing Fee: $20.00 plus $0.50 per page for the first 50 pages, then $0.25 per page for any additional pages. Maximum not to exceed $150. There is a fee for postage.

Payment is due at the time of request. Release is valid for 30 days.

If additional copies are desired after the valid date, there will be an additional charge.