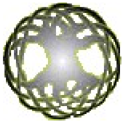

Su Fairchild, MD, ABFM, ABoIM
Genomic Medicine, Orthomolecular Integrative Medicine
Mailing address: PO Box 974, Bloomsburg, PA 17815
Phone: 703-828-4485 / Fax: 888-414-5264

Medical Records Release Authorization: *For continuation of care*

Name: ____DOB:___________

Address:____

City, State, zip:____

Records requested:____

__ Lab results (blood, saliva, urine) / __ Imaging study reports (ultrasound, MRI, CT, etc)

__ vaccination records / __ Consultation reports / __ Chart notes

__ Medication records / __ Other:_____________________________________

Date range of records requested:____

Records to be released from:

Dr____

Office address:____

City, State, zip:____

Phone:______________________________ Fax:_____________________________

Please release information to:

NPI: 1861488074
Su Fairchild MD
Fax: 888-414-5264
Phone: 703-828-4485
Email: sfairchildmd@gmail.com
PO Box 974, Bloomsburg, PA 17815

Dr Fairchild's office is largely paperless, and mailing of paper records is very strongly discouraged.
Fax is preferred as it is electronic and paperless.

I, the person named above, or legal guardian thereof, authorize the release of medical records as requested above.

This request is valid for 60 days from the date of signing, can be revoked in writing within those 60 days.

____ ______________
Signature Date