Physician Medical Record Request

William Sawchuk, M.D. & Gayle Masri-Fridling, M.D.

8320 Old Courthouse Road Vienna, VA 22182

Phone: {703) 532-7211 Fax: {703) 534-2874

Patient Information:

Name: ____ Date of Birth: _____________________

Street Address: ____

City: ___________________________________State: _____________________Zip:_________________

Information Requested:

☐ Office Visit Notes From: __________ To: __________ ☐ Pathology Reports

☐ Lab Reports Blood Tests ☐ Other: ____________________________________

Information to be released for the following reasons:

☐ Personal Record ☐ Transfer of Care ☐ Copy for my Primary Care Physician

☐ Other: ____

Information to be Released From:

Name of Physician, Clinic, Patient or Other: ____

Street Address: ____

City: _______________________________ State: ___________________________ Zip: _____________

Information to be Released to:

William Sawchuk, M.D. & Gayle Masri-Fridling, M.D.

8320 Old Courthouse Road, Suite 303

Vienna, VA 22182

Fax: (703) 532-7211

Patient Signature: ____Date: ____________________

Witness: ____Date: ____________________