

**Linda M. Bugbee, M.D.**  
**3420 Pump Rd #165**  
**Richmond, Virginia 23233**

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I hereby authorize Linda M. Bugbee, M.D. to release a copy of my medical records to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Patient Name (please print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email address (optional): \_\_\_\_\_

Guardian Signature (if patient is under 14): \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

***This authorization will remain in effect for 1 year from date of signature.  
Medical records will remain available for 6 years from the last date of visit.***

***Please enclose payment of \$50 made payable to "Linda Bugbee, MD" unless these records are being transferred to a physician.***