

Letter Request

Colleen Blanchfield, MD

11490 Commerce Park Drive Suite 420 Reston, VA 20191

Patient Name: _____ Phone # _____

To whom it shall be addressed: _____

Purpose of Letter: _____

Required Content:

**Please be advised that only the content specifically listed below will be included in the letter.
Please contact the recipient to ensure all requirements are included.*

Due Date: _____

Where to send:

Address: _____

Phone (required): _____

Fax (if available): _____

Please initial each of the following:

_____ Please allow two weeks for your letter to be written.

_____ There is a fee of \$200 per hour of time required for completion.

_____ Payment is due before the letter is sent.

Date Received: _____