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MEDICAL LETTER REQUEST

DATE OF REQUEST:______________

PATIENT NAME:____ **DOB:**_____________________

Printed Name of Responsible Party (if other than self): ____________________________________

Phone Number: (______)-_________-__________

*LETTER REQUESTS USUALLY TAKE 10-21 business days, detailed or customized letters may take longer. I understand that my account will be charged for this service. I understand the cost ranges from $25 and up depending on detail & length. All administrative fees are due at the time of service, any amounts left unpaid will be considered a past due amount. *By signing below I acknowledge that I have read and understand the above statement.*

Signature*:____

Please indicate primary purpose of letter **(standard diagnosis letter, school letter, etc)** If you are requesting a detailed letter please be specific with the information you would like to see in the letter.

Please select one method for the letter to be sent: (Please Circle One) Mailed Faxed Emailed
Provide the recipient's name and address/email/fax number below:

Office Use Only:

Date Completed: _____________ Sent: FAX, MAIL, Email

Total: $ _____________ Statement Sent: Yes / No Initials: _____

PAYMENT TYPE: Credit Card / Cash / Check