

Medical Records Request / Form Completion Receipt

Patient Name (*print*) _____ D.O.B. _____

\$25 Patient Copy of Medical record

\$15 Additional Copy MRI Disk (initial disk is free of charge)

\$15 Additional Copy of X-Ray Disk (initial disk is free of charge)

Form completion is charged out \$25 per form per diagnosis/disability period. Each additional form/diagnosis/disability period will be charged additionally.

\$25 One Diagnosis/Disability/FMLA form completion

\$20 Additional form completion

For Office Use Only **For Office Use Only** **For Office Use Only**

Acct # _____ Diagnosis: _____

Total Charged Amount: _____

Total Payment Received By: _____
Staff Name Date

_____ Cash
 _____ Check
 _____ Credit Card

Date of Request: _____

Date Request Completed: _____

Date Patient Notified of Completion: _____

Notes: