[Practice Name]

MEDICAL RECORDS INVOICE

Date		
Requested By		
Patient Name/DOB		Acct #

The information you requested is attached. A total of _____ pages were copied. Our charge is $_____per page for the first ___ pages; thereafter, _____ per page. A total of _____ pages were copied.

The total amount due is $_____.

Our tax identification number is _____.

Please remit payment by return mail to:

Practice Name_____

Address_____

_____

Thank you.

_____

Medical Records Department

[Practice Name]

MEDICAL RECORDS INVOICE

Date: _____

To: _____
_____
_____

Re: Request for medical records for
(Patient Name/DOB):_____

Dear_____:

A total of _____ pages were copied. Our charge is $_____per page for the first____pages; thereafter, _____ per page. A total of _____ pages were copied.

The total amount due is $_____. Please remit to: (Practice Name)_____, and mail to our office address, _____.

Our tax identification number is _____.

We will mail the records to you once we have received your payment.

Please call our office at xxx-xxx-xxxx if you have any questions.

Sincerely yours,

Office Administrator