AFFIDAVIT OF CUSTODIAN OF MEDICAL RECORDS

STATE OF _____

COUNTY OF _____

I, _____, am the duly authorized custodian of the medical records of _____, and as such have the authority to certify that medical records attached hereto constitute a true and correct copy of the medical records pertaining to the treatment of _____ at your office or institution from the _____ day of _____, 20___, to the _____ day of _____, 20___. The attached records were prepared by the personnel of _____, staff physicians, or persons acting under the control of either, in the ordinary course of business, at or near the time of treatment reported therein.

The reasonable charges incurred by _____ in furnishing the copy of these records is $_____.

_____
CUSTODIAN

SWORN TO AND SUBSCRIBED BEFORE ME, this the ____ day of _____, 20____.

_____
NOTARY PUBLIC

(SEAL)

My Commission Expires;
_____