
# Medical Records Request Form

Name of Medical Practice: _____

Patient Name: _____

DOB: _____

Date Requested: _____

Requested by: Patient [ ] Other [ ]_____

Delivery Method:

Mail [ ] Address: _____

Fax [ ] Number: _____

Pick Up [ ]

Please note:
All fees must be paid in full prior to our office sending out any medical records

| | | |
|---|---|---|
| Base Fee<br>(from one to 14 pages) | | $10.00 |
| From 15 to 25 pages ($0.75) | $ 0.75 x _____ pages | $_____ |
| From 26 to 99 pages ($0.50) | $ 0.50 x _____ pages | $_____ |
| 100 or more pages ($0.25) | $ 0.25 x _____ pages | $_____ |

Total: $_____