ACKNOWLEDGEMENT OF COPYING FEE

I, _____ (Parent / Guardian), understand
(PRINTED NAME)
that there will be a fee charged for copying medical records for any purpose. This fee is to be paid before records will be released. All records released require a signed release of information form, and no records will be copied before said form is completed and returned to us.

The fees for copying records for each patient chart requested are as follows:

Copying/Handling fee: **$15.00** per chart **($20.00** per chart is mailed)

_____ **Date**_____
Signature

_____
Relationship to patient(s):

Patient(s) chart requested:	**Date of Birth**
1. _____	_____/_____/_____
2. _____	_____/_____/_____
3. _____	_____/_____/_____
4. _____	_____/_____/_____
5. _____	_____/_____/_____
6. _____	_____/_____/_____