



MEDICAL LETTER REQUEST

DATE OF REQUEST: _____

PATIENT NAME: _____ DOB: _____

Printed Name of Responsible Party (if other than self): _____

Phone Number: (____) - _____ - _____

*LETTER REQUESTS **USUALLY TAKE 21 business days**, detailed or customized letters may take longer. I understand that my account will be charged for this service. I understand the cost ranges from \$25 and up depending on detail, length, and expedition requests. All administrative fees are due at the time of service, any amounts left unpaid will be considered a past due amount. *****Vaccine exemption requests: all vaccine exemption letters are based on patient history and diagnosis. Please be aware that there is no guarantee that this letter will be accepted. (COVID-19 vaccines only contraindications are a reaction to previous vaccines or an allergy to an ingredient in the vaccines)*****

By signing below I acknowledge that I have read and understand the above statement.

Signature*: _____

.....
Please indicate primary purpose of letter (standard diagnosis letter, school letter, etc) **If you are requesting a detailed letter please be specific with the information you would like to see in the letter**

.....
Please select one method for the letter to be sent: (Please Circle One) Mailed Faxed Emailed
Provide the recipient's name and address/email/fax number below:

Expedited Request: Date requested by: _____

We will do our best to expedite your request for you.

.....
Office Use Only:

Date Completed: _____ Sent: FAX, MAIL, Email

Total: \$ _____ Statement Sent: Yes / No Initials: _____