|  |  |
| --- | --- |
| [Company Name]  Name: [Name]  Street Address: [Street Address]  City, State: [City, State]  ZIP Code: [ZIP Code]  Phone: [Phone]  E-mail: [E-Mail] | **MEDICAL RECORDS REQUEST INVOICE** |

|  |  |
| --- | --- |
| Invoice # [No] | Date: XX, XX, XXXX |

Client / Customer

Name: [Name]

Street Address: [Street Address]

City, State: [City, State]

ZIP Code: [ZIP Code]

|  |  |  |  |
| --- | --- | --- | --- |
| **Description** | **Quantity** | **$ / Unit** | **Amount ($)** |
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|  |  |  |  |
| [Comments or Special Instructions] |  | SUBTOTAL |  |
|  |  | DISCOUNT |  |
|  |  | TAX |  |
| Payment is due within [Number (#)] days. |  | **TOTAL** |  |