Receipt for Medical Records

PATIENT_____ DATE_____

We have received your request for your medical records. To cover the cost of copying and mailing, state law provides for a charge of 75 cents per page plus postage.

We accept credit cards or cash for this service. Sorry, no checks.

CHARGE FOR YOUR RECORDS

COPYING _____ PAGES @ $0.75 _____

POSTAGE _____

TOTAL _____

PAYMENT INFORMATION

PAYMENT ☐ Visa ☐ MasterCard ☐ Cash

CARD NUMBER _____ CVC*_____

NAME ON CARD _____

CARD ADDRESS _____

CITY_____ STATE_____ ZIP_____

EXPIRATION DATE_____

TELEPHONE_____ E-MAIL_____

SIGNATURE_____

RECEIVED BY_____

*The CVC is the three-digit verification code at the end of the signature block on the back of your card.

969 Main Street, Suite D | Fishkill, NY 12524 | 845 896 7730 | 845 896 7758 fax
29 Fox Street, 4th Floor | Poughkeepsie, NY 12601 | 845 473 2350 | 845 473 4305 fax
40 Hurley Avenue, 3rd Floor | Kingston, NY 12401 | 845 338 3200 | 845 338 3233 fax