Harnett Health

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 (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: $_____