WILLIAM GAYÁ, M.D.

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RECORDS REQUEST - Must accompany each patient request

Patient Name (please print):_____
Last First M.I.

Date of Birth: _____ Social Security #: _____

Records requested:
___ All Records ___ Lab work/test results (please specify) _____

Send records to:

_____

_____

_____

MUST HAVE COMPLETE MAILING ADDRESS OR WE CANNOT PROCESS THIS REQUEST

CHARGES:

- Patient requesting records sent to self: 1-25 pgs. @ 1.00 page $_____
  Over 25 pgs. @ .25 cents a page $_____
- Patient requesting records faxed to a physician: **No charge**
- Forms completion: 1-2 pgs.10.00
  3-5 pgs.20.00
  +5 pgs.25.00
  $_____
- RUSH CHARGE $25.00 $_____

Total $_____

PLEASE ALLOW 10 BUSINESS DAYS TO COMPLETE YOUR REQUEST.

I have read and understand the above and agree to the terms as stated.

_____ _____
Patient/Legal Guardian Signature Date

We accept cash, check, and Visa/Mastercard. Payment must be received before records are released.

Credit Card #_____ Exp. date _____

Signature of Cardholder_____