Company Name: _____

Name: _____

Street Address: _____

City, State, Country: _____

ZIP: _____

Phone: _____

E-mail: _____

MEDICAL RECORDS REQUEST INVOICE

Invoice #: _____ Date: _____

Client / Customer

Name: _____

Street Address: _____

City, State: _____

ZIP: _____

Description	Quantity	$ / Unit	Amount ($)

Comments or Special Instructions:

_____

Payment is due within ____ days.

Subtotal	
Discount	
Tax	
TOTAL	

Thank you for your business!