ALL CHILDREN'S CLINIC, P.C.
3674 GOODMAN RD EAST, STE 9
SOUTHAVEN, MS 38671
PHONE 662-890-7747
FAX 662-890-3566

Date: _____

Dear Sir or Madam:

We have received a request for medical records from your firm on patient _____ Date of Birth ____/____/_____.

There is a service charge of $_____ associated with the release of this information. The medical records shall be released upon receipt of such payment.

Thank You,

All Children's Clinic, P.C.