ARIZONA PEDIATRIC CLINICS
Parent Form for Patient Letter Request

Phoenix Tempe

Patient Name: _____ DOB: _____

Parents Names: *(Both names are applicable)*
Mother: _____ Father: _____

Patient lives with: (*please check ONE)* _____ Both _____ Mother _____ Father

Street Address: _____ APT: _____

City: _____ State: _____ ZIP Code: _____

Daytime Phone Number: ( ) _____ Cell Phone: ( ) _____

Name of Person or Company requesting letter: _____

Purpose of the Letter: _____

How should the letter be addressed? _____ Dear *(You fill in the name)* _____

_____ *To Whom It May Concern* _____ *Dear Sirs or Madame*

What **exact information** should be contained in this letter? Please include **date range** and **original document requesting this information from your doctor.**

_____
_____
_____
_____

Number of copies needed? _____Billing information? _____ Vaccine information? _____
Pick-up date: _____ Do you want it mailed? _____

Cost: $20 Date Paid: _____ Initials: _____

PLEASE NOTE: Cost must be <u>PRE-PAID</u> before letter will be generated.

Signature: _____ Date: _____

Provider approval: _____ Date: _____

Confirm diagnosis in chart: _____

Additional information from provider:

_____

_____

Completed by: _____ Date: _____