Medical Records Request Invoice

From	Bill To
Company Name: ______	Name: ______
Name: ______	Street Address: ______
Street Address: ______	City, State: ______
ZIP: ______	ZIP: ______
Phone: ______	Phone: ______
E-mail: ______	E-mail: ______

Invoice Number	Date	Invoice Due Date
______	______	______

Description	Quantity	$ / Unit	Amount ($)

Comments or Special Instructions:

______

Payment is due within ______ days

Subtotal	
Discount	
Tax	
TOTAL	