

**LETTER / FORM COMPLETION REQUEST**

Patient Name (Print): \_\_\_\_\_

DOB: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Person Making Request:  Self  Other \_\_\_\_\_

If other, relationship to patient: \_\_\_\_\_

Patients' Provider:  Dr. Roy Jackson  Dr. Lillian Ngaw

Please Send Letter to:  The Address Above  Pick-up  The Address Below

Please Mail Letter to:

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Please describe the nature of the letter you need:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I the undersigned am legally authorized to make this request. I also understand and agree that depending on the nature and length of the letter or form that I may have to pay an administrative fee of \$15 or more to complete my request.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signed Date

\_\_\_\_\_  
Print Name