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**Kit Carson County
 Health Service
 District**

FAX

To:	From: Director of Health Information
Fax:	Total # Pages:
Phone:	Date Faxed:
Re:	Phone: 719-346-4770

ITIMIZED BILL FOR RECOVERY OF REASONABLE COST

Date: _____

To: _____

From: Kit Carson County Health Service District

Patient Name: _____ MR# _____

Dates of Service: _____

Reproduction costs:

0-5 pages, No charge

€ 6-15 pages—10.00 fee \$ _____

€ >15 pages—\$10.00 + \$0.25 per page (# pages _____) \$ _____

Other costs: _____ \$ _____

_____ \$ _____

Total Costs: \$ _____

Please make check payable to Kit Carson County Health Service District, Attention: Business Office. Pre-Payment is required for all medical records requests.

Medical records will be mailed upon receipt of the above amount.

Medical records are enclosed

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