AIM Center
for Health and Wellness

promoting the health and well-being of our patients

Dear Patient:

Effective immediately, all requests for letters or forms requiring a physician signature will require a window of completion of **10** to **14** business days. A fee of $25 will be charged for each form or letter needed.

Please provide front desk staff with the following information:

Date:	
Patient's Name:	**Patient's DOB:**
Name of Person Requesting Information:	
Contact Number:	**Relationship to Patient:**

Completed information should be returned via:

- ○ Phone: _____
- ○ Fax: _____
- ○ Mail: _____

_____

This request is for:

- ○ Howard Anderson Jr., M.D.
- ○ Mollie Dorrough, M.D.
- ○ Kimberly Johnson, D.O.
- ○ Keira Scanks, M.D.

Thank you for your cooperation in this matter.

For Office Use Only:		
○ $25 fee paid	Date Received:	Received by:
○ $25 fee not paid		