



Michael F. Cantwell MD, MPH
(CA License #: G060393)

1501 Clement Street | San Francisco, Ca 94118
Phone: (415) 831-4412 | Fax: (415) 831-4416
www.mcmed.us | kerry@mcmed.us

Letter Request Form

Patient Name: _____ Date of Birth: _____

Purpose of Letter: _____ Due date: _____
(i.e. disability, insurance/HSA, airline, jury duty) (Please allow 2wk turnaround)

Who should the letter be addressed to? _____

How should we send this letter? (Please check box(s) below and fill in ALL information)

☐ US MAIL Address: _____
☐ Regular mail (additional \$.75) _____
☐ Priority mail with signature _____
required (additional \$12.00) _____

☐ FAX
Fax number(s): _____

☐ EMAIL (non-HIPPA)
☐ Email address: _____
☐ Patient Copy via email: _____

What would you like discussed in this letter?

If this is not enough space please attach an additional page.

By signing this letter request form, I agree to the following:

Fee's for the letter listed below or any additional fees selected above are due before letter is released.

Short letters (that do not require your chart being pulled) \$15

Longer letters (require chart pulling, research or additional information) \$30

If you have selected your letter to be sent by email, you understand and agree that it will be sent over a non-HIPPA compliant email.

Signature of Requestor: _____ Date: _____