

# PROFESSIONAL MEDICAL COPIES, INC.



## Release of Information / Copy Service Inquiry

Facility name:

Contact name/Title:

E-mail Address:

Phone number:

Best time to call:

Facility address(es):

**So that we might better understand your needs, please fill in the following:**

Anticipated volume of copy work: # of files/charts \_\_\_\_ per  day  
 week  
 month  
(Please check one)

What percentage of this work would we be billing to other parties?

What percentage of this work would be for transfer of care, direct patient requests, or as required for insurance billing and audits?

Please indicate whether your records are  paper,  electronic:  
(Please check all that apply)

Do you have an offsite storage facility we would need to access in conjunction with our service?  Yes,  No

If yes, please provide detail:

P.O. BOX 4518, PARKER, COLORADO 80134  
PHONE (303) 850-9594 ♦ FAX (303) 850-9598

<https://promedcopies.com>