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To whom it may concern:

We have received the request for medical records on _________________________

DOB: _____________________

We will send the requested records **via fax** once we receive a

payment of $_____________

Payment can be made in form of a check, <u>payable to Dr. Michael Wayne.</u>

Please mail your payment to:

Dr. Michael Wayne

42931 W. Seven Mile Road

Northville, MI 48167

If you have any further questions please call our office at (248)348-8700.

Thank you in advance.