

REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth: _____

Patient Address _____

City, State, Zip _____

Requesting

- Office Notes
- Pathology Report
- Lab Results
- Entire Chart

I understand and agree that I may be financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information.

I understand that the charge for this service would be \$14.00 No charge

Signature of Patient or Legal Guardian _____

Date _____

Print Name of Patient or Legal Guardian _____

Please release my records by:

Faxing to number _____
Please note that records must be 5 pages or less to fax

Mailing to above address

Mailing to alternate address _____

Patient in office to pick records up