

**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