



**REQUEST TO COPY PROTECTED HEALTH INFORMATION
(RECORDS RELEASE)**

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street

Apartment #

City, State, Zip

I understand and agree that I am 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 copying my Protected Health Information is \$10.00.

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

**FOR INTERNAL PURPOSES
ONLY:**

04/18/11/DP

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