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 PHI is $10.00.

____ ________________________________
Signature of Patient or Legal Guardian Date

____
Print Name of Patient or Legal Guardian

FOR INTERNAL PURPOSES ONLY: