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Request to Inspect and Copy Protected Health Information

Patient Name:_____ Date of Birth:_____

Reason for Transferring (Moving/New Insurance/Other):_____

New Physician Address:_____
Street Ste #

_____
City State Zip Code

I understand and agree that I am financially responsible for the following fees associated with my request: Copying charges, including the cost of labor and (in some cases) postage related to the production of my information. I understand the charge for this service is an initial fee of $10.00 plus 50¢ a page for the first 50 pages and 25¢ for each additional page.

_____ _____
(Signature of Parent or Legal Guardian) (Date)

_____
(Printed Name of Parent or Legal Guardian)

Contact Number(s) where you can best be reached:_____

Office Use Only

Okay to Copy Records?

□ Yes or □ No

Chart total $_____

Records Faxed/Mailed on: _____