REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name:____ Date of Birth:________

Patient Address:____

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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 this service is $10.00.

____ ___________________

Signature of Patient or Legal Guardian Date

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Print Name of Patient or Legal Guardian