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REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

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 this service is \$0.75 per page, with a minimum charge of \$35.00.

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian