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## **Request to Inspect and Copy Protected Health Information (PHI)**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 \$ 25.00, which is a flat fee charged to all patients requesting copies of records.

\_\_\_\_\_  
**Signature of Patient or Legal Guardian** **Date**

\_\_\_\_\_  
**Print Name of Patient or Legal Guardian**