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REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name: _____ D.O.B. _____
Address:_____ M.R. # _____
_____

I hereby request the following protected health information to be provided to me from Dr. Shevin's office. Information should include: _____
_____, from dates _____ through _____.

I understand and agree that the following fees will be charged to me for this request: copying charges, including the cost of supplies and labor, and postage. I understand that the charge for this service is $0.10 per page, with a minimum charge of $ 0.00.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Name of Patient or Legal Guardian Relationship

Date Request Received in Office: _____

Date Information Sent to Patient: _____