Request to Inspect and Copy Protected Health Information

EAST PENN DERMATOLOGY, P.C.
1140 WELSH ROAD, SUITE 130
NORTH WALES, PA 19454

Patient Name: _____Date of Birth: _____

Patient Address: _____
Street Apt. #

_____
City, State Zip

I am requesting to review or copy _____
(Please fill in specific record to be copied)

_____

I understand and agree that I am financially responsible for the following fees associated with my request for protected health information: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the cost for this service is $_____.

Records should be:

_____ mailed to me at _____

_____ faxed to me at _____

_____ picked up at office by _____

_____ other _____

_____
Signature Patient or Legal Guardian Date

_____ Patient / Parent / Legal Guardian / POA
Print Name of Patient or Legal Guardian Circle one

Phone number if you prefer to be called when records are ready to be picked up: _____

Form Dated 8/22/2013