



Physicians to Children, Inc.

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REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street/Apt. #

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 \$.50 per page up to 50 pages, \$.25 per page 51 pages and up. (may be waived for immunization records and/or last physical)

Signature of Patient or Legal Guardian _____ Date _____

Print Name of Patient or Legal Guardian _____

Circle: Immunization Records Copy of Last Physical

Copy of Records for the Last Two Years/Reason Needed: _____

Other: _____

Please be aware that ID will be required when records are picked up.